AND
BRIEFS

Supreme Court, U.S.
FILED
DEC 19 2016
OFFICE OF THE CLERK

No. 16-149

IN THE
Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ Of Certiorari
To The Supreme Court Of Missouri

JOINT APPENDIX

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Counsel for Respondent

PETITION FOR WRIT OF CERTIORARI FILED
AUGUST 1, 2016
CERTIORARI GRANTED NOVEMBER 4, 2016

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NOTICE

The following documents have been omitted in printing this joint appendix because they appear on the following pages in the appendix to the petition for a writ of certiorari:

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11SL-CC00535 - JODIE NEVILS V GROUPHEALTH PLAN INC (E-CASE)
Docket Entries

04/01/2011 **Removed to Fed Court**

03/31/2011 **Certification Filed**
Clerk's certification.

Notice
Notice of filing of removal

03/11/2011 **Agent Served**
Document ID - 11-SMCC-1962; Served To - GROUP HEALTH PLAN INC; Server - ; Served Date - 02-MAR-11; Served Time - 00:00:00; Service Type - Special Process Server; Reason Description Served

02/14/2011 **Summons Issued-Circuit**
Document ID: 11-SMCC-1962, for GROUP HEALTH PLAN INC. - MAILED TO ATTORNEY

02/09/2011 **Filing:**
FILING INFORMATION SHEET

Pet Filed in Circuit Ct

Judge Assigned
DIV 3

11SL-CC00535-01 - JODIE NEVILS V GROUPHEALTH PLAN INC
Docket Entries

07/31/2012 **Certif Copies/Leg File Prepard**
Certified Copy of Supplement to Legal File Prepare for S. TO, ATTORNEY FOR THE APPELLANT.

06/12/2012 **Ackn Notice of Appeal Filed**

06/08/2012 **Certif Copies/Leg File Prepared**
Certified Copy of Legal File Prepared FOR S. TO, ATTORNEY FOR THE APPELLANT.

06/05/2012 **Judge/Clerk - Note**
COPY OF JODIE NEVILS, PLAINTIFF NOTICE OF APPEAL MAILED TO MISSOURI COURT OF APPEALS WITH CHECK # 21SL1721297. FORWARDED COPIES OF PLAINTIFF'S NOTICE OF APPEAL BY REGULAR MAIL TO THOMAS DEE 190 CARONDELET PLAZA STE. 600 ST. LOUIS, MO. 63105 & WINTHROP REED 600 WASHINGTON AVE., STE. 2500 ST. LOUIS, MO. 63101.

05/29/2012 **Appeal Filed**
NOTICE OF APPEAL FILED & $70.00 FEE PAID BY APLT STEPHANIE H. TO; #61149; REC# 21SL1721297;

JODIE NEVILS APPEALS
Filed By: JODIE NEVILS

Appeal Costs Taxed
NOTICE OF APPEAL FILED & $70.00 FEE PAID BY APLT STEPHANIE H. TO #61149; PLT JODIE NEVILS APPEALS
Filed By: JODIE NEVILS

05/21/2012 **Judgment Entered**
DFT Group Health Plan Inc.'s Motion for Summary Judgment is Granted DFT ACS Recovery Services Inc,'s Motion for Summary Judgment is Granted All other orders per memo SO ORDERED: JUDGE THEA A. SHERRY

Other Final Disposition

04/16/2012 **Response Filed**
to Notice of Supplemental Authority
Filed By: ACS RECOVERY SERVICES INC

04/13/2012 **Response Filed**
to Notice of Supplemental Authority
Filed By: GROUP HEALTH PLAN INC

Response Filed
to Notice of Supplemental Authority
Filed By: GROUP HEALTH PLAN INC

04/04/2012 **Filing:**
Notice of Supplemental Authority
Filed By: JODIE NEVILS

02/24/2012 **Memorandum Filed**
DEFENDANT ACS' MEMORANDUM TO THE COURT IN RESPONSE TO PLAINTIFF'S LETTER

02/21/2012 **Correspondence Filed**
LETTER FILED
Filed By: JOHN ERIC CAMPBELL

01/27/2012 **Motion Hearing Held**
MTN FOR SUMMARY JUDGMENT CALLED. MTN'S TAKEN UNDER SUBMISSION SO ORDERED: JUDGE SHERRY
Scheduled For: 01/27/2012; 1:30 PM ; THEA A SHERRY; St Louis County

01/26/2012 **Reply**
REPLY OF ACS RECOVERY SVC IN SUPPORT OF MTN FOR SUMMARY JUDGMENT
Filed By: JOHN ERIC CAMPBELL

01/23/2012 **Order Granting Ext of Time**

01/11/2012 **Filing:**
PLT'S OPPOSITION TO DFT ACS RECOVERY SERVICES INC'S

MOTION FOR SUMMARY JUDGMENT

01/04/2012 **Order of Dismissal**
STIPULATION OF DISMISSAL FILED. COUNTERCLAIMANT/DEFENDANT ACS RECOVERY SERVICES DISMISSES ITS COUNTERCLAIM WITHOUT PREJUDICE. SO ORDERED: JUDGE SHERRY

12/30/2011 **Judge Assigned**
Cause reassigned to Judge Thea A. Sherry for hearing and determination effective January 1, 2012, per Presiding Judges Administrative Order.

12/20/2011 **Motion for Extension of Time**
Motion for Extension of Time to file a Responsive or Answer to Defendant ACS Recovery Service Counterclaim
Filed By: JODIE NEVILS

12/15/2011 **Motion Filed**
MOTION TO APPLY SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

12/14/2011 **Correspondence Sent**
Copy of Notices Filed and Mailed This Day to the Parties of Record.

12/13/2011 **Motion for Leave**
Filed By: JODIE NEVILS

Reply
PLT'S PROPOSED SUR REPLY
Filed By: JODIE NEVILS

12/01/2011 **Memorandum Filed**
MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT
Filed By: ACS RECOVERY SERVICES INC

Motion for Summary Judgment
AND STATEMENT OF UNCONTROVERTED FACTS
Filed By: ACS RECOVERY SERVICES INC

11/22/2011 **Answer Filed**
FIRST AMENDED ANSWER, AFFIRMATAIVE DEFENSES AND COUNTERCLAIM TO FIRST AMENDED CLASS ACTION PETITION
Filed By: ACS RECOVERY SERVICES INC

Reply
MEMORANDUM IN SUPPORT OF MT FOR SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

11/09/2011 **Answer Filed**
AND AFFIRMATIVE DEFENSES TO FIRST AMENDED PETITION
Filed By: GROUP HEALTH PLAN INC

11/07/2011 **Order Granting Ext of Time**
Unopposed Request for Extension of Time Copeis mailed SO ORDERED: JUDGE ELLEN LEVY SIWAK

Order of Dismissal
Cross-Claim Plaintiff ACS Recovery Services, Inc., DISMISSES its Cross Claim without prejudice Copies mailed SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 08/26/2011 - Cross Claim Filed

11/04/2011 **Answer Filed**
AFFIRMATIVE DEFENSES AND COUNTERCLAIM
Filed By: ACS RECOVERY SERVICES INC

11/01/2011 **Order**
Cosent for Plaintiff's First Amended Class Action Peittion For Damages Copies handed SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 10/31/2011 - Amended Motion/Petition Filed

10/31/2011 **Amended Motion/Petition Filed**
First Amended Class Action Peittion For Damages
Filed By: JODIE NEVILS
Associated Entries: 11/01/2011 - Order

10/27/2011 **Motion Hearing Scheduled**
DFTS MOTION FOR SUMMARY JUDGMENT
Associated Entries: 01/27/2012 - Motion Hearing Held
Scheduled For: 01/27/2012; 1:30 PM ; THEA A SHERRY; St Louis County

Notice of Hearing Filed
DFTS MOTION FOR SUMMARY JUDGMENT
Filed By: MELISSA ZIGLER BARIS

10/21/2011 **Response Filed**
IN OPPOSITION TO DEFT'S MT FOR SUMMARY JUDGMENT W/SUGGESTIONS IN SUPPORT
Filed By: JODIE NEVILS

10/20/2011 **Certificate of Service**

10/06/2011 **Order**
ORDER SUSTAINING PLTS MOTION FOR EXTENSION OF TIME THE COURT TAKES UP AND CONSIDERS

PLTS MOTION FOR EXTENSION OF TIME IN WHICH TO RESPOND TO DFTS MOTION FOR SUMMARY JUDGMENT AND AFTER BEING FULLY AND DULY ADVISED IN THE PREMISES HEREBY SUSTAINS THE MOTION PLTS RESPONSE TO DFTS MOTION FOR SUMMARY JUDGMENT IS NOW DUE 10/20/11 COPIES MAILED TO ATTYS OF RECORD (10/6/11) SO ORDERED: JUDGE ELLEN LEVY SIWAK

Motion Granted/Sustained
PLTS MOTION FOR EXTENSION OF TIME SO ORDERED: JUDGE ELLEN LEVY SIWAK

Associated Entries: 10/04/2011 - Motion Filed

Order
HAVING BEEN APPRISED THAT NO PARTY OBJECTS TO MOTIONT O INTERVENE AND FOR GOOD CUASE SHOWN, MOTION TO INTERVENE GRANTED ON BASIS THAT IT IS UNOPPOSED MOTION HEARING IS CANCELED COPIES MAILED TO ATTYS OF RECORD SO ORDERED: ELLEN LEVY SIWAK

Hearing/Trial Cancelled

Scheduled For: 11/10/2011; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

Motion Granted/Sustained
MOTION TO INTERVENE SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 09/16/2011 - Filing:

10/04/2011 **Motion Filed**
PLTS MOTION FOR EXTENSION OF TIME TO RESPOND TO DFTS MOTION FOR SUMMARY JUDGMENT W/ATTACHED FAX COVER SHEET
Filed By: JODIE NEVILS
Associated Entries: 10/06/2011 - Motion Granted/Sustained

09/16/2011 **Filing:**
APPLICANT ACS'S UNOPPOSED SUPPLEMENTAL MEMORANDUM IN SUPPORT OF MT TO INTERVENE
Associated Entries: 10/06/2011 - Motion Granted/Sustained

09/12/2011 **Memorandum Filed**

09/08/2011 **Motion Hearing Scheduled**
Associated Entries: 10/06/2011 - Hearing/Trial Cancelled
Scheduled For: 11/10/2011; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

09/07/2011 **Filing:**
STATEMENT OF UNCONTROVERTED MATERIAL FACTS IN SUPPORT OF MT SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

Filing:
SUGGESTIONS IN SUPPORT OF MT FOR SUMMARY JUDGMENT
Filed By: GROUP HEALTH PLAN INC

Motion for Summary Judgment
Filed By: GROUP HEALTH PLAN INC

08/26/2011 **Motion to Intervene**
Filed By: STEVEN DAVID HALL

Cross Claim Filed
CROSS-CLAIM OF PLAINTIFF/INTERVENOR ACS RECOVERY SERVICES, INC., AGAINST PLAINTIFF YOUNG FOR A DECLARATORY JUDGMENT FILED.
Filed By: STEVEN DAVID HALL
Associated Entries: 11/07/2011 - Order of Dismissal

Entry of Appearance Filed
ENTER THEIR APPEARANCE AS ATTORNEYS FOR APPLICANT ACS RECOVERY SERVICE
Filed By: STEVEN DAVID HALL

08/25/2011 **Certificate of Mailing**

07/15/2011 **Answer Filed**
Deft's Answer and Affirmative Defenses
Filed By: GROUP HEALTH PLAN INC

07/11/2011 **Filing:**
COPY OF NOTICE FILED AND MAILED TO PARTIES OF RECORD

07/07/2011 **Motion Granted/Sustained**
Plf's motion for change of judge, granted
SO ORDERED: JUDGE MARK D. SEIGEL
Associated Entries: 07/06/2011 - Motion for Change of Judge

Judge Assigned
The Above Cause is Assigned to Division 11, By Order of the Presiding Judge, For Hearing and Determination. Notice Mailed This Day to Parties of Record and Copy Filed.

07/06/2011 **Motion for Change of Judge**
Filed By: JOHN ERIC CAMPBELL
Associated Entries: 07/07/2011 - Motion Granted/Sustained

06/15/2011 **Order**
COPY OF MEMORANDUM AND ORDER OF REMAND

11SL-CC00535-02 - JODIE NEVILS V GROUPHEALTH PLAN INC
Docket Entries

06/21/2016 **Order for Stay**
SO ORDERED: JUDGE ELLEN LEVY SIWAK
Associated Entries: 06/16/2016 - Proposed Order Filed

Hearing/Trial Cancelled
Stay Order Granted
Scheduled For: 06/24/2016; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

06/16/2016 **Proposed Order Filed**
Proposed Order; Electronic Filing Certificate of Service.
Filed By: THOMAS N STERCHI
On Behalf Of: GROUP HEALTH PLAN INC
Associated Entries: 06/21/2016 - Order for Stay

Motion to Stay
JOINT MOTION OF ALL PARTIES TO STAY PROCEEDINGS; Electronic Filing Certificate of Service.
Filed By: THOMAS N STERCHI
On Behalf Of: GROUP HEALTH PLAN INC

05/23/2016 **Mandate from Supreme Ct of MO**
The judgment by the Circuit Court of St. Louis County be reversed, annulled and for naught held and esteemed, and that the said Appellant be restored to all things which he has lost by reason of said judgment. It is further considered and adjudged by the court that the said cause be remanded to the said Circuit Court of St. Louis County for further proceedings to be had therein, in conformity with the opinion of this court herein delivered; and that the said Appellant recover against the said Respondents costs and charges herein expended, and have execution therefor.
**********OPINION FILED**********

09/22/2015 **Counsel Status Hrng Scheduled**
SO ORDERED: JUDGE ELLEN LEVY SIWAK

Associated Entries: 06/21/2016 - Hearing/Trial Cancelled
Scheduled For: 06/24/2016; 9:00 AM ; ELLEN LEVY SIWAK; St Louis County

08/26/2015 **Judge/Clerk - Note**
MANDATE FROM MISSOURI SUPREME COURT, FILED ON FEBRUARY 24, 2014, RETURNED TO SUPREME COURT AS REQUESTED.

08/14/2015 **Correspondence Filed**
LETTER RECEIVED FROM MISSOURI SUPREME COURT, REQUESTING RETURN OF MANDATE FILED ON FEBRUARY 24, 2014.

02/19/2015 **Hearing/Trial Cancelled**
See 4/3/14 Order to Stay
Scheduled For: 03/18/2015; 12:00 AM ; ELLEN LEVY SIWAK; St Louis County

02/10/2015 **Correspondence Sent**

Dismissal Hearing Scheduled
Associated Entries: 02/19/2015 - Hearing/Trial Cancelled
Scheduled For: 03/18/2015; 12:00 AM ; ELLEN LEVY SIWAK; St Louis County

01/15/2015 **Order of Dismissal**
Defendant Xerox REcovery Services, Inc ONLY Dismiissed with prejudice SO ORDERED: JUDGE ELLEN LEVY SIWAK

01/05/2015 **Notice of Dismissal**
Notice of Dismissal of Defendant ACS; Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of: JODIE NEVILS

12/31/2014 **Judge Assigned**
Cause reassigned to Judge Ellen Levy Siwak for hearing and determination effective January 1, 2015, per Presiding Judges Administrative Order.

12/03/2014 **Hearing/Trial Cancelled**
Scheduled For: 12/03/2014; 9:00 AM ; THEA A SHERRY; St Louis County

04/29/2014 **Case Mgmt Conf Scheduled**
Associated Entries: 12/03/2014 - Hearing/Trial Cancelled
Scheduled For: 12/03/2014; 9:00 AM ; THEA A SHERRY; St Louis County

Order
On the Court's own motion, the Court sets this matter for a status/case management conference on December 3, 2014 at 9:00 a,m, unless there has been a final disposition with regard to the petition for Writ of Certiorari before the Supreme Court prior to that date. Copies sent to attorneys of record SO ORDERED: JUDGE THEA A. SHERRY

04/03/2014 **Order**
Upon Joint Motion of all parties to this action, and for good cause shown, it is hereby Ordered that: 1. All further proceedings on this action are hereby stayed until such time as the United

States Supreme Court finally disposes of Defendants' petition for writ of certiorari, including any briefing and argument on the merits and issuance of any opinion. 2. Defendants shall apprise this Court of any final disposition by the United States Supreme Court with regard to its petition for writ of certiorari, within 10 days of such disposition. 3. The Case Management Conference scheduled for April 2, 2014 is hereby adjourned without date. Copies mailed to attorneys of record. SO ORDERED: JUDGE THEA A. SHERRY

Hearing/Trial Cancelled
Scheduled For: 04/16/2014; 9:00 AM ; THEA A SHERRY; St Louis County

03/31/2014 **Case Mgmt Conf Scheduled**
Comes now Coventry Health Care and with consent of counsel requests the court to remove the case management conference from the April 2, 2014 docket and reset the case management conference for April 16, 2014 at 9:00 a.m. SO ORDERED: JUDGE THEA A. SHERRY
Associated Entries: 04/03/2014 - Hearing/Trial Cancelled
Scheduled For: 04/16/2014; 9:00 AM ; THEA A SHERRY; St Louis County

Hearing Continued/Rescheduled
Hearing Continued From:

04/02/2014; 9:00 AM Case Management Conference

03/27/2014 **Entry of Appearance Filed**
Filed By: THOMAS N STERCHI

Motion to Withdraw
Motion to withdraw as counsel. SO ORDERED: JUDGE THEA A. SHERRY
Filed By: MELISSA ZIGLER BARIS

Motion Filed
Joint motion of all parties to stay proceedings

02/28/2014 **Case Mgmt Conf Scheduled**
Associated Entries: 03/31/2014 - Hearing Continued/Rescheduled
Scheduled For: 04/02/2014; 9:00 AM ; THEA A SHERRY; St Louis County

Notice of Hearing Filed
Copies sent to parties of record SO ORDERED: JUDGE THEA A. SHERRY

02/21/2014 **Reopen From Mandate**

U.S. DISTRICT COURT
Eastern District of
Missouri (St. Louis)
CIVIL DOCKET FOR CASE #:
4:11-cv-00588-DDN

Nevils v. Group Health Plan, Inc.
Assigned to: Magistrate Judge David D. Noce
Case in other court: St. Louis County Circuit Court, 11ST-CC00535
Cause: 05:8901 Federal Employees Health Benefits Act

Date Filed: 03/31/2011
Date Terminated: 06/16/2011
Jury Demand: None
Nature of Suit: 890 Other Statutory Actions
Jurisdiction: Federal Question

Date Filed	#	Docket Text
03/31/2011	1	NOTICE OF REMOVAL from St. Louis County Circuit Court, case number 11SL-CC00535, with receipt number 0865-2693554, in the amount of $350 Jury Demand,, filed by Group Health Plan, Inc.. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C, # 4 Exhibit D, # 5 Exhibit E, # 6 Exhibit F, # 7 Exhibit G, # 8 Exhibit H, # 9 Exhibit I, # 10 Exhibit J, # 11 Original Filing Form, # 12 Civil Cover Sheet, # 13 Certificate of Interest, # 14 Entry of

		Appearance of Thomas Dee)(Dee, Thomas) (Entered: 03/31/2011)
03/31/2011	2	NOTICE OF FILING NOTICE OF REMOVAL filed by Defendant Group Health Plan, Inc. Sent To: St. Louis County Circuit Court executed by State Court Clerk (Dee, Thomas) (Entered: 03/31/2011)
03/31/2011	3	DISCLOSURE OF CORPORATION INTERESTS CERTIFICATE by Defendant Group Health Plan, Inc. (KLK) (Entered: 04/01/2011)
03/31/2011	4	Complaint (Removal) Received From: St. Louis County Circuit Court filed by Jodie Nevils.(KLK) (Entered: 04/01/2011)
04/01/2011	5	ENTRY of Appearance by Melissa Z. Baris for Defendant Group Health Plan, Inc.. (Baris, Melissa) (Entered: 04/01/2011)
04/01/2011	6	ENTRY of Appearance by Elizabeth A. Mushill for Defendant Group Health Plan, Inc.. (Mushill, Elizabeth) (Entered: 04/01/2011)
04/01/2011		Case Opening Notification. Consents issued 2. Judge Assigned: Honorable David D. Noce. (KLK) (Entered: 04/01/2011)
04/01/2011		Pursuant to Local Rule 2.08, the assigned/referred magistrate

		judge is designated and authorized by the court to exercise full authority in this assigned/referred action or matter under 28 U.S.C. Sec. 636 and 18 U.S.C Sec. 3401. (CSAW) (Entered: 04/01/2011)
04/07/2011	7	ANSWER to Complaint by Group Health Plan, Inc.. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3)(Dee, Thomas) (Entered: 04/07/2011)
04/07/2011	8	MOTION for Judgment on the Pleadings by Defendant Group Health Plan, Inc. (Dee, Thomas) (Entered: 04/07/2011)
04/07/2011	9	MEMORANDUM in Support of Motion re 8 MOTION for Judgment on the Pleadings filed by Defendant Group Health Plan, Inc.. (Dee, Thomas) (Entered: 04/07/2011)
04/12/2011	10	MOTION for Extension of Time to File Response/Reply as to 8 MOTION for Judgment on the Pleadings by Plaintiff Jodie Nevils. (Campbell, John) (Entered: 04/12/2011)
04/13/2011	11	Docket Text ORDER: Re: 10 MOTION for Extension of Time up to and including April 25, 2011, to File Response/Reply as to 8 MOTION for Judgment on the Pleadings by Plaintiff Jodie

		Nevils. (Campbell, John); ORDERED GRANTED. Signed by Magistrate Judge David D. Noce on 4/13/11. (KXS) (Entered: 04/13/2011)
04/25/2011	13	RESPONSE to Motion re 8 MOTION for Judgment on the Pleadings filed by Plaintiff Jodie Nevils. (Campbell, John) (Entered: 04/25/2011)
04/27/2011	14	SCHEDULING ORDER: IT IS HEREBY ORDERED that the court will hear oral argument on defendant's motion for judgment on the pleadings (Doc. 8) at the May 19, 2011 scheduling conference. Signed by Magistrate Judge David D. Noce on 4/27/11. (KKS) (Entered: 04/27/2011)
04/27/2011	15	RULE 16 ORDER Joint Scheduling Plan due by 5/13/2011. Rule 16 Conference set for 5/19/2011 02:00 PM in Courtroom 17N before Magistrate Judge David D. Noce. Magistrate Consent due by 4/28/2011.. Signed by Magistrate Judge David D. Noce on 4/27/11. (KKS) (Entered: 04/27/2011)
04/27/2011		Receipt 4644021228 in the amount of $100.00 for PRO HAC VICE on behalf of Don P. Saxton (CCAM) (Entered: 04/28/2011)

04/27/2011		Receipt 4644021228 in the amount of $100.00 for PRO HAC VICE on behalf of Mitchell L. Burgess (CCAM) (Entered: 04/28/2011)
04/27/2011		Receipt 4644021228 in the amount of $100.00 for PRO HAC VICE on behalf of Ralph K. Phalen (CCAM) (Entered: 04/28/2011)
04/27/2011	16	MOTION for Leave to Appear Pro Hac Vice Mitchell L. Burgess (Filing fee $100) by Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
04/27/2011	17	MOTION for Leave to Appear Pro Hac Vice Don P. Saxton (Filing fee $100) by Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
04/27/2011	18	MOTION for Leave to Appear Pro Hac Vice Ralph K. Phalen (Filing fee $100) by Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
04/27/2011	19	FULL CONSENT has been received by by Defendant Group Health Plan, Inc., Plaintiff Jodie Nevils. (DJO) (Entered: 04/28/2011)
05/02/2011	20	Docket Text ORDER Re: 18 MOTION for Leave to Appear Pro Hac Vice Ralph K. Phalen 17 MOTION for Leave to Appear Pro Hac Vice Don P. Saxton 16 MOTION for Leave to Appear Pro

		Hac Vice Mitchell L. Burgess; ORDERED GRANTED. Signed by Magistrate Judge David D. Noce on 5/2/2011. (KMS) (Entered: 05/02/2011)
05/02/2011		ORDER RECEIPT: (see receipt) Docket No: 20, sent to parties not set up for electronic notification Mon May 2 14:29:40 CDT 2011 (Scheele, Kara) (Entered: 05/02/2011)
05/02/2011	21	MOTION to Remand Case to State Court by Plaintiff Jodie Nevils. (Phalen, Ralph) (Entered: 05/02/2011)
05/04/2011	22	Joint MOTION to Stay *discovery pending court ruling on current motions* by Plaintiff Jodie Nevils. (Phalen, Ralph) (Entered: 05/04/2011)
05/05/2011	23	REPLY to Response to Motion re 8 MOTION for Judgment on the Pleadings filed by Defendant Group Health Plan, Inc.. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Dee, Thomas) (Entered: 05/05/2011)
05/09/2011	24	ORDER; IT IS HEREBY ORDERED that the joint motion of the parties to stay discovery pending resolution of the motion to remand and motion for judgment on the pleadings (Doc. 22) is sustained. IT IS

		FURTHER ORDERED that the court will hear oral argument on the motion to remand Thursday, May 19, 2011 at 2:30 p.m. in lieu of the Rule 16 conference. IT IS FURTHER ORDERED the order setting this case for a Rule 16 conference is vacated. Signed by Magistrate Judge David D. Noce on 05/09/2011. (DJO) (Entered: 05/09/2011)
05/09/2011		ORDER RECEIPT: (see receipt) Docket No: 24. to non–registered party Mon May 9 09:39:03 CDT 2011 (O'Leary, Deborah) (Entered: 05/09/2011)
05/12/2011	25	MEMORANDUM in Opposition re 21 MOTION to Remand Case to State Court filed by Defendant Group Health Plan, Inc.. (Dee, Thomas) (Entered: 05/12/2011)
05/17/2011	26	Consent MOTION to Continue oral argument by Plaintiff Jodie Nevils. (Phalen, Ralph) (Entered: 05/17/2011)
05/18/2011	27	ORDER IT IS HEREBY ORDERED that plaintiff's consent motion to continue oral arguments (Doc. 26) is sustained. Oral arguments on defendant's motion to remand are rescheduled for June 2, 2011 at 10:00 am. 26 Signed by Magistrate Judge David D. Noce on 5/18/11. (KXS)

		(Entered: 05/18/2011)
05/23/2011	28	REPLY IN SUPPORT OF MOTION 21 to Remand Case to State Court by Plaintiff Jodie Nevils. (Saxton, Don) Modified on 5/24/2011 (KKS). (Entered: 05/23/2011)
06/02/2011	29	Minute Entry for proceedings held before Magistrate Judge David D. Noce: Motion Hearing held on 6/2/2011 re 21 MOTION to Remand Case to State Court filed by Jodie Nevils; arguments heard; matter taken under submission. (FTR Gold Operator initials:K. Spurgeon.) (FTR Gold: Yes.) (KXS) (Entered: 06/02/2011)
06/06/2011	30	Supplemental to 21 MOTION to Remand Case to State Court *Supplemental Authority* by Defendant Group Health Plan, Inc.. (Dee, Thomas) Modified on 6/10/2011 (KMS). (Entered: 06/06/2011)
06/15/2011	31	MEMORANDUM AND ORDER OF REMAND; For the reasons set forth above, IT IS HEREBY ORDERED that the motion of plaintiff Jodie Nevils to remand (Doc. 21) is hereby sustained. The case is remanded to the Circuit Court of St. Louis County for further proceedings. IT IS FURTHER ORDERED that the

		motion of defendant Group Health Plan, Inc. for judgment on the pleadings (Doc. 8) is deferred to the Missouri circuit court. Signed by Magistrate Judge David D. Noce on 06/15/2011. (DJO) (Certified copy of order to St. Louis County Circuit Court, 7900 Carondelet, Clayton, MO 63105); (Entered: 06/15/2011)

ED98538 - JODIE NEVILS, APP V. GROUP HEALTH, ET AL., RES
Docket Entries

03/21/2013 **Disp-Tran W/ Opin SC- SC Ord**
CASE TRANSFERRED TO SUPREME COURT

03/19/2013 **Sustained**
Associated Entries: 02/13/2013 - Appl for Tran SC Filed in SC
Associated Entries: 02/13/2013 Appl for Tran SC Filed In SC

02/13/2013 **Note to Clerk eFiling**
Filed By: BLAKE PATRICK GREEN

Appl for Tran SC Filed in SC
Application for Transfer - Sup Ct; E D Opinion; Motion for Rehearing; Application for Transfer - ED; Notice Denying Transfer and Rehearing; Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 03/19/2013 - Sustained

Appl for Tran SC Filed in SC
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 03/19/2013 - Sustained

01/29/2013 **Denied**
Associated Entries: 01/09/2013 - Application for Transfer to SC
Associated Entries: 01/09/2013 - Motion for Rehearing

01/09/2013 **Application for Transfer to SC**
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 01/29/2013 - Denied

Motion for Rehearing
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 01/29/2013 – Denied

12/26/2012 **Clerk Remark**
VOTE
Opinion- Affirmed
Signed Majority Opinion

12/11/2012 **Case Submitted**
Scheduled For: 12/11/2012; DIVISION 1; EASTERN DISTRICT CT OF APPEALS

11/27/2012 **Paper Copy of Document Receivd**
Appellants Reply Brief

11/21/2012 **Granted**
Associated Entries: 11/20/2012 - Mot File BrfsLonger Rule Allow

Granted Until
November 21, 2012
Associated Entries: 11/20/2012 - Mot Ext Time File Reply Brf

11/20/2012 **Paper Copy of Document Due**
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Note to Clerk eFiling
Filed By: BLAKE PATRICK GREEN

Appellant's Reply Brief
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

Mot File BrfsLonger Rule Allow
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 11/21/2012 - Granted

Mot Ext Time File Reply Brf
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 11/21/2012 - Granted Until

10/31/2012 **Paper Copy of Document Receivd**
Amicus Curiae Brief

10/30/2012 **Granted Until**
November 19, 2012
Associated Entries: 10/29/2012 - Mot Ext Time File Reply Brf

Granted
Associated Entries: 10/25/2012 - Amicus Curiae Mot to File Brf

10/29/2012 **Suggestions in Opposition**
Sugg in Opp to Amicus Filing;
Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of; JODIE NEVILS
Associated Entries: 10/25/2012 -

Amicus Curiae Brief

Mot Ext Time File Reply Brf
Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of: JODIE NEVILS
Associated Entries: 10/30/2012 - Granted Until

Paper Copy of Document Receivd
Respondents Brief

10/25/2012 **Appendix Filed**
Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

Paper Copy of Document Due
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Respondent's Brief
Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

Paper Copy of Document Receivd
RESPONDENTS BRIEF

Appendix Filed
Electronic Filing Certificate of Service.
Filed By: WINTHROP BLACKSTONE REED III
On Behalf Of: ACS RECOVERY SERVICES, INC.

Paper Copy of Document Due
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Respondent's Brief
Electronic Filing Certificate of Service.
Filed By: WINTHROP BLACKSTONE REED III
On Behalf Of: ACS RECOVERY SERVICES, INC.

Paper Copy of Document Due
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Amicus Curiae Brief
Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
Associated Entries: 10/29/2012 - Suggestions in Opposition

Amicus Curiae Mot to File Brf
Filed By: NICHOLAS PATRICK LLEWELLYN
Associated Entries: 10/30/2012 - Granted

10/05/2012 **Case Docketed**
DIVISION 1: Ahrens, Clifford H., P.J.; Sullivan, Sherri B., J; Norton, Glenn A., J. December 11, 2012
Docket attached

09/21/2012 **Granted Until**
October 25, 2012
Associated Entries: 09/20/2012 - Mot for Ext Time to File Brief

09/20/2012 **Mot for Ext Time to File Brief**
Electronic Filing Certificate of Service.
Filed By: MELISSA Z. BARIS
On Behalf Of: GROUP HEALTH PLAN, INC., ACS RECOVERY SERVICES, INC.
Associated Entries: 09/21/2012 - Granted Until

Req for Oral Argument Filed
Respondent GHP Health Plan, Inc Request for Oral Argument; Electronic Filing Certificate of Service
Filed By: MELISSA Z. BARIS
On Behalf Of: GROUP HEALTH PLAN, INC.

Req for Oral Argument Filed
Request for Oral Argument; Electronic Filing Certificate of Service.
Filed By: STEVEN DAVID HALL
On Behalf Of: ACS RECOVERY SERVICES, INC.

09/13/2012 **Case Screened- Regular**
ORAL ARGUMENT LETTER ATTACHED

09/12/2012 **Paper Copy of Document Receivd**
Appellant Brief

09/10/2012 **Paper Copy of Document Due**
Four paper copies of brief due within five days. E.D. Rule 333 (d).

Appellant's Brief
Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS

08/22/2012 **Granted Until**
September 10, 2012
Associated Entries: 08/22/2012 - Motion for Extension of Time

Motion for Extension of Time
Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
Associated Entries: 08/22/2012 - Granted Until

08/09/2012 **Paper Copy of Document Due**
One paper copy of record due within five days. E.D. Rule 333 (c).

Supplemental Legal File
Supp Legal File; Electronic Filing

Certificate of Service.
Filed By: STEVEN DAVID HALL
On Behalf Of: ACS RECOVERY SERVICES, INC.

Paper Copy of Document Receivd
SUPPLEMENTAL LEGAL FILE AND INDEX OF RESPONDENT ACS RECOVERY SERVICES, INC.

07/05/2012 **Entry of Appearance Filed**
Electronic Filing Certificate of Service.
Filed By: WINTHROP BLACKSTONE REED III
On Behalf Of: ACS RECOVERY SERVICES, INC.

06/26/2012 **Paper Copy of Document Received**
7 VOLUMES OF LEGAL FILES

06/25/2012 **Paper Copy of Document Due**
One paper copy of record due within five days. E.D. Rule 333 (c).

Legal File/ROA Complete
Pl s Legal File and Index- Vol 1; Pl s Legal File and Index- Vol 2; Pl s Legal File and Index- Vol 3; Legal File and Index- Vol 4; Pl s Legal File and Index- Vol 5; Pl s Legal File and Index- Vol 6; Pl s File and Index- Vol 7; Electronic Filing Certificate of Service.
Filed By: STEPHANIE HING-YIN TO

On Behalf Of: JODIE NEVILS

06/11/2012	**Correspondence Sent** Efiling notice sent by mail to Don Saxton and Thomas Dee **Acknowledgement Letter Sent**
06/08/2012	**NOA Filed in Appellate Court**
05/29/2012	**Suppl Ntc Appl-Legal File Only** **Filing Fee Paid** **NOA Filed in Circuit Court**

SC93134 - JODIE NEVILS,APP V GROUP HEALTH PLAN,INC,ETAL,RES (E-CASE)
Docket Entries

08/05/2016 **Correspondence Received**
LETTER DATED AUGUST 2, 2016, RECEIVED FROM THE SUPREME COURT OF THE UNITED STATES

05/19/2016 **Case Disp- Opin & Mandate Sent**
CERTIFIED COPY OF OPINION AND MANDATE SENT TO THE CIRCUIT CLERK OF ST. LOUIS COUNTY. OPINION RELEASE SHEET MAILED TO CAROL MEHLE WITH THOMSON REUTERS.

05/03/2016 **Concurring Opinion**
Author of Opinion - Paul C. Wilson

Opinion Reversed & Remanded
FISCHER, STITH, DRAPER AND RUSSELL, JJ., CONCUR; WILSON, J., CONCURS IN RESULT SEPARATE OPINION FILED; BRECKENRIDGE, C.J., FISCHER, STITH, DRAPER AND RUSSELL, JJ., CONCUR IN OPINION OF WILSON, J. MOTIONS FOR REHEARING MUST BE FILED WITHIN 15 DAYS FROM THIS DATE (RULE 84.17). THE PROVISIONS OF RULE 44.01(E) DO NOT APPLY TO EXTEND THE TIME FOR FILING MOTIONS FOR REHEARING.

Signed Majority Opinion
Author of Opinion - Richard B. Teitelman

04/01/2016 **Correspondence Received**
Notice of Supplemental Authority; Exhibit A; Electronic Filing Certificate of Service.
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

12/15/2015 **Correspondence Received**
Letter - Cases Discussed During Argument That Were Not Cited in Briefs; Electronic Filing Certificate of Service.
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

12/10/2015 **Case Submitted**
ARGUED AND SUBMITTED.
Scheduled For: 12/10/2015; ; SUPREME COURT OF MISSOURI; Setting: 5; SUPREME COURT OF MISSOURI

11/30/2015 **Appellant's Reply Brief**
Appellant's Reply Brief; Electronic Filing Certificate of Service.
Filed By: JOHN ERIC CAMPBELL
On Behalf Of: JODIE NEVILS

11/25/2015 Notice
Letter re: oral argument; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

11/23/2015 Sustained Until
ORDER ISSUED: APPELLANT'S MOTION FOR EXTENSION OF TIME TO FILE REPLY BRIEF REMAND SUSTAINED. APPELLANT'S REPLY BRIEF IS NOW DUE ON OR BEFORE NOVEMBER 30, 2015.
Associated Entries: 11/22/2015 - Mot Ext Time File Reply Brf

11/22/2015 Mot Ext Time File Reply Brf
APPELLANT'S MOTION FOR EXTENSION OF ONE BUSINESS DAY TO FILE APPELLANT'S REPLY BRIEF, TO NOVEMBER 30, 2015; Electronic Filing Certificate of Service.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 11/23/2015 - Sustained Until

11/16/2015 Filing
Letter regarding position of parties on the filing of amicus brief; Electronic Filing Certificate of Service.

Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

Amicus Curiae Brief
Amicus Curiae Brief of the United States in Support of Respondent; Electronic Filing Certificate of Service. THIS BRIEF WAS FILED WITH THE CONSENT OF THE PARTIES.
Filed By: NICHOLAS PATRICK LLEWELLYN

Respondent's Brief
RESPONDENT'S BRIEF ON REMAND; APPENDIX TO RESPONDENT S BRIEF ON REMAND Cover to A 62; APPENDIX TO RESPONDENTS BRIEF ON REMAND A 63 TO A 100; APPENDIX TO RESPONDENTS BRIEF ON REMAND A 101 TO A 177; APPENDIX TO RESPONDENTS BRIEF REMAND A 178 TO A 371; APPENDIX TO RESPONDENTS BRIEF ON REMAND A 372 TO A 541 END; Electronic Filing Certificate of Service.
Filed By: DAVID M EISENBERG
On Behalf Of: GROUP HEALTH PLAN, INC., ACS RECOVERY SERVICES, INC.

10/22/2015 Case Docketed

CAUSE DOCKETED FOR ORAL ARGUMENT ON DECEMBER 10, 2015. PLEASE SEE ATTACHED DOCKET LETTER, DOCKET, AND NOTICES TO COUNSEL.

Sustained
ORDER ISSUED:RESPONDENTS' UNOPPOSED MOTION TO RESCHEDULE ORAL ARGUMENT DOCKET SUSTAINED. CAUSE REMOVED FROM THE ORAL ARGUMENT DOCKET FOR DECEMBER 1, 2015. CAUSE ORDERED DOCKETED FOR ORAL ARGUMENT ON DECEMBER 10, 2015.

Associated Entries: 10/22/2015 - Mot Reschedule Case on Docket

Mot Reschedule Case on Docket
RESPONDENT'S UNOPPOSED MOTION TO RESCHEDULE ORAL ARGUMENT; EXHIBIT A; Electronic Filing Certificate of Service.

Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.
Associated Entries: 10/22/2015 - Sustained

Sustained
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS

GRANTED TO ATTORNEY MIGUEL A. ESTRADA. THE E-FILING SYSTEM WILL NOT SERVE OUT OF STATE COUNSEL. LOCAL COUNSEL IS RESPONSIBLE FOR ADVISING OUT OF STATE COUNSEL OF ALL FILINGS AND RULINGS.

Associated Entries: 10/21/2015 - Motion for Pro Hac Vice

Sustained
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS GRANTED TO ATTORNEY JONATHAN C. BOND. THE E-FILING SYSTEM WILL NOT SERVE OUT OF STATE COUNSEL. LOCAL COUNSEL IS RESPONSIBLE FOR NOTIFIYING OUT OF STATE COUNSEL OF ALL FILINGS AND RULINGS.

Associated Entries: 10/21/2015 - Motion for Pro Hac Vice

10/21/2015 **Motion for Pro Hac Vice**
RESPONDENT'S MOTION FOR PRO HAC VICE ADMISSION OF JONATHAN C. BOND; Exhibit A; Exhibit B; Electronic Filing Certificate of Service.

Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

Associated Entries: 10/22/2015 - Sustained

Motion for Pro Hac Vice
RESPONDENT'S MOTION FOR PRO HAC VICE ADMISSION OF MIGUEL A. ESTRADA; Exhibit A; Exhibit B; Electronic Filing Certificate of Service.
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.
Associated Entries: 10/22/2015 – Sustained

Entry of Appearance Filed
ENTRY OF APPEARANCE; Electronic Filing Certificate of Service.
Filed By: DAVID M EISENBERG
On Behalf Of: GROUP HEALTH PLAN, INC.

10/20/2015 **Clerk Remark**
CAUSE DOCKETED FOR ORAL ARGUMENT ON DECEMBER 1, 2015. PLEASE SEE ATTACHED DOCKET LETTER, DOCKET, AND NOTICES TO COUNSEL.

10/06/2015 **Sustained**
ORDER ISSUED: APPELLANT'S MOTION FOR LEAVE TO FILE BRIEF AND APPENDIX ON REMAND ONE DAY OUT OF TIME SUSTAINED. SAID BRIEF AND APPENDIX ARE DUE ON THIS DATE.
Associated Entries: 10/06/2015 - Mot to File Brief Out of Time

Appellant's Brief
APPELLANT'S BRIEF ON REMAND; APPELLANT'S APPENDIX ON REMAND; Electronic Filing Certificate of Service.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS

Mot to File Brief Out of Time
Motion for Leave to File Appellant's Brief and Appendix One Day Out of Time; Electronic Filing Certificate of Service.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 10/06/2015 - Sustained

09/04/2015 **Sustained**
ORDER ISSUED: APPELLANT'S AMENDED UNOPPOSED MOTION TO REVISE BRIEFING SCHEDULE SUSTAINED. APPELLANT'S BRIEF ON REMAND IS DUE ON OR BEFORE OCTOBER 5, 2015. RESPONDENTS' BRIEF ON REMAND IS DUE ON OR BEFORE NOVEMBER 16, 2015. APPELLANT'S REPLY BRIEF ON REMAND, IF ANY, IS DUE TEN DAYS THEREAFTER. FURTHER EXTENSION REQUESTS WILL NOT BE VIEWED WITH FAVOR. NOTE TO

COUNSEL FROM THE CLERK'S OFFICE: ORAL ARGUMENT DATES FOR DECEMBER 2015, ARE DECEMBER 1, 2015, DECEMBER 2, 2015, DECEMBER 9, 2015, AND DECEMBER 10, 2015

Associated Entries: 09/03/2015 - Mot Ext Time to File Brief

Overruled
ORDER ISSUED: APPELLANT'S UNOPPOSED MOTION FOR ADDITIONAL TIME TO FILE APPELLANT'S BRIEF OVERRULED AS MOOT.

Associated Entries: 09/03/2015 - Mot Ext Time to File Brief

09/03/2015 **Mot Ext Time to File Brief**
Amended Unopposed Motion to Revise Briefing Schedule; Electronic Filing Certificate of Service.

Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 09/04/2015 - Sustained

Mot Ext Time to File Brief
Appellant's Unopposed Motion for Additional Time to File Appellant's Brief to October 5, 2015; Electronic Filing Certificate of Service.

Filed By: ERICH VINCENT

VIETH
On Behalf Of: JODIE NEVILS
Associated Entries: 09/04/2015 - Overruled

08/31/2015 **Correspondence Received**
MANDATE DATED FEBRUARY 4, 2014, RETURNED TO THIS OFFICE BY THE CIRCUIT CLERK ST. LOUIS COUNTY.

08/18/2015 **Court Order Issued**
ORDER ISSUED: APPELLANT SHALL FILE THE FIRST AND LAST BRIEF IN THIS CAUSE.

08/14/2015 **Court Order Issued**
ORDER ISSUED: IN LIGHT OF THE MANDATE OF THE SUPREME COURT OF THE UNITED STATES DATED JUNE 29, 2015, THE OPINION ISSUED IN THIS CAUSE ON FEBRUARY 4, 2015, IS VACATED AND THE MANDATE ISSUED ON FEBRUARY 21 , 2015, SENT TO THE CIRCUIT CLERK OF ST. LOUIS COUNTY IS HEREBY RECALLED. THE PARTIES SHALL FILE BRIEFS PURSUANT TO THE BRIEFING SCHEDULE SET FORTH IN SUPREME COURT RULE 84.24(l). LETTER SENT TO THE ST. LOUIS COUNTY CIRCUIT CLERK REQUESTING RETURN OF THE MANDATE AND ADVISING CAROL

MEHLE WITH THOMSON REUTERS OF THE ORDER.

08/06/2015 **Correspondence Received**
Letter to Clerk Requesting Additional Briefing/Argument; Electronic Filing Certificate of Service.
Filed By: JOHN ERIC CAMPBELL
On Behalf Of: JODIE NEVILS

08/05/2015 **Filing**
MANDATE AND SUMMARY DISPOSITION OF THE SUPREME COURT OF THE UNITED STATES FILED.

07/27/2015 **Note to Clerk eFiling**
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

Filing
Filed By: THOMAS N. STERCHI
On Behalf Of: GROUP HEALTH PLAN, INC.

07/06/2015 **Correspondence Received**
LETTER DATED JUNE 29, 2015, FROM THE SUPREME COURT OF THE UNITED STATES RECEIVED ADVISING THAT THE PETITION FOR WRIT OF CERTIORARI WAS GRANTED AND THE JUDGMENT IS VACATED AND REMANDED TO THE

SUPREME COURT OF MISSOURI FOR FURTHER CONSIDERATION IN LIGHT OF NEW REGULATIONS. THE MANDATE OF THE SUPREME COURT OF THE UNITED STATES WILL ISSUE NO EARLIER THAN 25 DAYS FROM JUNE 29, 2015.

05/05/2014 **Correspondence Received**
LETTER DATED APRIL 28, 2014, FROM THE SUPREME COURT OF THE UNITED STATES RECEIVED.

02/21/2014 **Filing**
CERTIFIED COPY OF OPINION AND MANDATE SENT TO THE CIRCUIT CLERK OF ST. LOUIS COUNTY. OPINION RELEASE SHEET FAXED AND MAILED TO CAROL MEHLE WITH THOMSON REUTERS

02/04/2014 **Concurring Opinion**
Author of Opinion - Paul C. Wilson

Opinion Reversed & Remanded
RUSSELL, C.J ., FISCHER, STITH AND DRAPER, JJ., CONCUR; WILSON, J., CONCURS IN SEPARATE OPINION FILED; BRECKENRIDGE, J., CONCURS IN OPINION OF WILSON, J. MOTIONS FOR REHEARING MUST BE FILED WITHIN 15 DAYS FROM THIS DATE (RULE 84.17). THE PROVISIONS OF

RULE 44.01(E) DO NOT APPLY TO EXTEND THE TIME FOR FILING MOTIONS FOR REHEARING.

Signed Majority Opinion
Author of Opinion - Richard B. Teitelman

09/12/2013 **Case Submitted**
ARGUED AND SUBMITTED.
Scheduled For: 09/12/2013; ; SUPREME COURT OF MISSOURI; Setting: 3; SUPREME COURT OF MISSOURI

09/10/2013 **Filing**
Letter to Court re Kobold v Aetna; Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

08/09/2013 **Sustained**
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS GRANTED TO HENRY C. WHITAKER. NOTE: LOCAL COUNSEL MUST ADVISE OUT OF STATE COUNSEL OF ALL FILINGS, ORDERS OR RULINGS AS THE E-FILING SYSTEM CURRENTLY CANNOT SERVE OUT OF STATE COUNSEL.
Associated Entries: 08/08/2013 -

Motion for Pro Hac Vice

08/08/2013 **Motion for Pro Hac Vice**
Motion for admission pro hac vice; Affidavit; Fee receipt; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA
Associated Entries: 08/09/2013 - Sustained

07/24/2013 **Sustained**
ORDER ISSUED:AMICUS CURIAE UNITED STATES OF AMERICA'S UNOPPOSED MOTION TO PARTICIPATE IN ORAL ARGUMENT SUSTAINED. AMICUS CURIAE SHALL SHARE TIME FOR ARGUMENT WITH RESPONDENTS.
Associated Entries: 07/22/2013 - Motion for Oral Argument

07/22/2013 **Motion for Oral Argument**
Unopposed Motion for Leave to Participate in Oral Argument; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA
Associated Entries: 07/24/2013 – Sustained

07/15/2013 **Case Docketed**
CAUSE DOCKETED FOR ORAL ARGUMENT ON SEPTEMBER 12, 2013. PLEASE SEE ATTACHED DOCKET LETTER, DOCKET AND NOTICES TO COUNSEL.

06/17/2013 **Substitute Reply Brief**
of Appellant filed with service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

06/07/2013 **Note to Clerk eFiling**
Filed By: NICHOLAS PATRICK LLEWELLYN

Filing
Corrected letter regarding supplemental authority; Supreme Court opinion; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

06/05/2013 **Filing**
Correspondence to Clerk Under Rule 84 20; Opinion of U S Supreme Court Hillman v Maretta; Electronic Filing Certificate of Service.
Filed By: CHRISTOPHER OWEN BAUMAN

On Behalf Of: ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS

05/30/2013 **Sustained Until**
ORDER ISSUED: APPELLANT'S MOTION FOR EXTENSION OF TIME TO FILE SUBSTITUTE REPLY BRIEF SUSTAINED. APPELLANT'S SUBSTITUTE REPLY BRIEF IS NOW DUE ON OR BEFORE JUNE 17, 2013.
Associated Entries: 05/29/2013 - Mot Ext Time File Reply Brf

05/29/2013 **Mot Ext Time File Reply Brf**
Motion for Extension of Time to File Reply; Electronic Filing Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 05/30/2013 - Sustained Until

05/23/2013 **Note to Clerk eFiling**
Filed By: MARK G. ARNOLD.

Substitute Respondent's Brief
Substitute Brief of Respondents GHP and ACS; Electronic Filing Certificate of Service. RESPONDENT'S SUBSTITUTE BRIEF AND APPENDIX
Filed By: MARK G. ARNOLD
On Behalf Of: GROUP HEALTH

PLAN, INC., ACS RECOVERY SERVICES, INC.

Amicus Curiae Brief
Amicus Curiae Brief of the United States in Support of Respondents; Appendix to Amicus Curiae the United States; Electronic Filing Certificate of Service. ORDERED FILED "AS IS" ON THIS DATE. SEE RULE 81.18
Filed By: NICHOLAS PATRICK LLEWELLYN
On Behalf Of: UNITED STATES OF AMERICA

Amicus Curiae Brief
Brief of Amicus Curiae Association of Federal Health Organizations; Electronic Filing Certificate of Service.
Filed By: CHRISTOPHER OWEN BAUMAN
On Behalf Of: ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS

Sustained
ORDER ISSUED: RULE 9.03 VISITING ATTORNEY STATUS GRANTED TO DAVID ERMER AS CO-COUNSEL FOR AMICUS CURIAE THE ASSOCATION OF FEDERAL HEALTH ORGANIZATIONS. LOCAL COUNSEL IS REQUIRED TO ADVISE MR. ERMER OF ALL FILINGS AND

RULINGS AS MR. ERMER WILL NOT BE SERVED VIA THE E-FILING SYSTEM AT THIS TIME.

Associated Entries: 05/22/2013 - Motion for Pro Hac Vice

05/22/2013 **Motion for Pro Hac Vice**

Motion for Admission of Visiting Attorney to Appear in this Matter; Application to Appear Pro Hac Electronic Filing Certificate of Service.

Filed By: CHRISTOPHER OWEN BAUMAN

On Behalf Of: ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS

Associated Entries: 05/23/2013 - Sustained

Sustained

ORDER ISSUED: THE MOTION OF THE ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS SUSTAINED.

Associated Entries: 05/22/2013 - Amicus Curiae Mot to File Brf

Amicus Curiae Mot to File Brf

Filed By: CHRISTOPHER OWEN BAUMAN

On Behalf Of: ASSOCIATION OF FEDERAL HEALTH

ORGANIZATIONS
Associated Entries: 05/22/2013 - Sustained

Sustained
ORDER ISSUED: ATTORNEY STEPHANIE H. TO'S MOTION TO WITHDRAW AS COUNSEL FOR APPELLANT SUSTAINED.
Associated Entries: 05/22/2013 - Mot for Withdrawal of Counsel

Mot for Withdrawal of Counsel
Motion to Withdraw; Electronic Filing Certificate of Service.
Filed By: STEPHANIE HING-YIN TO
Associated Entries: 05/22/2013 – Sustained

05/16/2013 **Sustained**
ORDER ISSUED: THE MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF OF THE UNITED STATES OF AMERICA SUSTAINED.
Associated Entries: 05/16/2013 - Amicus Curiae Mot to File Brf

Entry of Appearance Filed
Entry of Appearance; Electronic Filing Certificate of Service.
Filed By: MARK G. ARNOLD
On Behalf Of: GROUP HEALTH PLAN, INC.

Amicus Curiae Mot to File Brf
Motion for leave to file amicus curiae brief; Electronic Filing Certificate of Service.
Filed By: NICHOLAS PATRICK LLEWELLYN
Associated Entries: 05/16/2013 - Sustained

Notice
Notice of Change of Address; Electronic Filing Certificate of Service. NOTICE OF CHANGE OF ADDRESS FOR ATTORNEYS ERICH VIETH AND JOHN CAMPBELL FILED WITH SERVICE.
Filed By: ERICH VINCENT VIETH
On Behalf Of: JODIE NEVILS

Entry of Appearance Filed
Filed By: STEPHANIE HING-YIN TO
On Behalf Of: JODIE NEVILS

05/02/2013 **Sustained Until**
ORDER ISSUED: RESPONDENTS' MOTION FOR EXTENSION OF TIME TO FILE SUBSTITUTE BRIEFS SUSTAINED. RESPONDENTS' SUBSTITUTE BRIEFS ARE DUE ON OR BEFORE MAY 23, 2013.
Associated Entries: 05/02/2013 - Mot Ext Time to File Brief

Mot Ext Time to File Brief
Unopposed joint motion to extend the time to file brief; Electronic Filing Certificate of Service.
Filed By: STEVEN DAVID HALL
Associated Entries: 05/02/2013 - Sustained Until

04/19/2013 **Substitute Appellant's Brief**
Appellant's Substitute Brief and Appendix to Appellant Substitute Brief filed with service. Electronic Certificate of Service.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

04/05/2013 **Sustained Until**
ORDER ISSUED: APPELLANT'S MOTION FOR EXTENSION OF TIME TO FILE APPELLANT'S SUBSTITUTE BRIEF SUSTAINED. APPELLANT'S SUBSTITUTE BRIEF IS NOW DUE ON OR BEFORE APRIL 19, 2013.
Associated Entries: 04/04/2013 - Mot Ext Time to File Brief

04/04/2013 **Mot Ext Time to File Brief**
Motion for Extension of Time for Appellant's Brief filed with service. Electronic Filing Certificate of Service.
Filed By: MITCHELL LEE BURGESS
On Behalf Of: JODIE NEVILS

Associated Entries: 04/05/2013 - Sustained Until

03/21/2013 **Record on Appeal Transferred**
CLERK, MISSOURI COURT OF APPEALS, EASTERN DISTRICT, FILED THE ENTIRE FILE HEREIN IN ACCORDANCE WITH THE ORDER OF THIS COURT DATED MARCH 19, 2013. THE FILE CONSISTS OF THE NOTICE OF APPEAL, RECORD ON APPEAL (SEVEN VOLUMES OF LEGAL FILE), APPELLANT'S BRIEF, AMICUS CURIAE BRIEF OF U.S., RESPONDENT ACS RECOVERY SERVICES, INC.'S BRIEF, RESPONDENT GROUP HEALTH PLAN, INC.'S BRIEF, APPELLANT'S REPLY BRIEF, AND CASE RELATED DOCUMENTS.

03/19/2013 **App Sustnd/Cause Ordered Tran**
APPELLANT'S APPLICATION FOR TRANSFER FROM THE MISSOURI COURT OF APPEALS, EASTERN DISTRICT, SUSTAINED AND CAUSE ORDERED TRANSFERRED. MANDATE SENT TO CLERK, MISSOURI COURT OF APPEALS, EASTERN DISTRICT, VIA E-MAIL AND TO ALL COUNSEL OF RECORD VIA THE MISSOURI EFILING SYSTEM. COUNSEL OF RECORD MAY WISH TO REVIEW RULE 83.08.
Associated Entries: 02/13/2013 -

Appl for Tran SC Filed in SC

02/22/2013 **Filing**
Letter with Supplemental Authority; Calingo 11 CV628 Order and Judgment; Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

02/20/2013 **Suggestions in Opposition**
Respondent s Opposition to Application for Transfer.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH PLAN, INC.

02/19/2013 **Sustained**
ORDER ISSUED: RESPONDENT GROUP HEALTH PLAN INC.'S MOTION FOR LEAVE TO FILE SUGGESTIONS IN OPPOSITION SUSTAINED. SAID SUGGESTIONS IN OPPOSITION ARE DUE ON OR BEFORE FEBRUARY 20, 2013.
Associated Entries: 02/19/2013 - Other Motion

Other Motion
Motion for Leave to File Opposition to Application for Transfer; Electronic Filing Certificate of Service.
Filed By: THOMAS MCKEE DEE
On Behalf Of: GROUP HEALTH

PLAN, INC.
Associated Entries: 02/19/2013 – Sustained

02/13/2013 **Filing Fee Paid**
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

Filing Info Sheet eFiling
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

Appl for Tran SC Filed in SC
Appellant's Application for Transfer from the Missouri Court of Appeals, Eastern District; ED Opinion; Motion for Rehearing Filed in ED; Application for Transfer Flied in ED; Notice Denying Rehearing and Transfer.
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS
Associated Entries: 03/19/2013 - App Sustnd/Cause Ordered Tran

Transfer Summary - Form 15
Form 15 - Cover Page to Application for Transfer
Filed By: BLAKE PATRICK GREEN
On Behalf Of: JODIE NEVILS

CLASS ACTION PETITION FOR DAMAGES
(Mo. Cir. Ct. Feb. 14, 2011)

Plaintiff, Jodie Nevils, on behalf of himself and all others similarly situated, alleges and avers the following for this class action against Defendant:

INTRODUCTION AND BACKGROUND

1. This action is brought by the Plaintiff on behalf of himself and others similarly situated regarding the Defendant's practice of asserting liens and/or rights of reimbursement against the personal injury settlements of Plaintiff and the Class Members when the Defendant has no legal right to assert said liens.

2. Defendant Group Health Plan, Inc. ("Group Health Plan") is a private corporate entity that contracts to provide health insurance to individual persons.

3. Upon information and belief, Group Health Plan contracts with the Federal government, through the Office of Personnel Management as a "carrier" to administer healthcare benefits in accordance with the provisions of the Federal Employee Health Benefits Act (FEHBA). 5 U.S.C. § 8901 *et. seq*.

4. FEHBA is a comprehensive statutory and regulatory scheme that provides federal employees, federal retirees, and their eligible family members with subsidized healthcare benefits.

5. The Defendant routinely engages in a widespread pattern and practice of unlawfully asserting reimbursement rights on healthcare benefits that are paid pursuant to health plans subject to the provisions of FEHBA.

6. For instance, occasionally an individual is injured in an auto accident and that individual's health care benefits are covered through a FEHBA plan. If that individual pursues legal action against the tortfeasor for his/her injuries, the Defendant unlawfully assert a lien for repayment of the health care benefits paid for such treatment.

7. Absent a Federal provision that affords lien/subrogation rights to an FEHBA "carrier" such as Group Health Plan, such rights, if they exist, are wholly derivative of state law.

8. There is no Federal provision that provides lien and/or subrogation rights to reimbursement for benefits paid by a FEHBA "carrier" such as Defendant Group Health Plan.

9. Under Missouri law, subrogation on personal injury claims is prohibited. Accordingly, since Missouri law controls whatever reimbursement rights to which the Defendant would be entitled, Defendant has no right of reimbursement for benefits paid pursuant to a FEHBA health plan.

10. Despite the fact that any reimbursement/subrogation rights are controlled by Missouri state law that prohibits such subrogation, Defendant routinely asserts liens on personal injury recoveries of Missouri citizens and subrogate for repayment of health benefits paid out on personal injury claims of Missouri citizens.

11. Defendant pursues such course of conduct despite being informed repeatedly that they are not entitled to reimbursement of such funds under Missouri law.

12. By employing such a policy and business model, Defendant has unlawfully violated the rights

of Plaintiff and the Class members as described more particularly below.

13. Further, such conduct of the Defendant, and their agents, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiff and the Class members such that punitive damages are appropriate and warranted.

JURISDICTION AND VENUE

14. This Court has personal jurisdiction over Defendant Group Health Plain since the Defendant transacted business in Missouri, violated the law within the State of Missouri, and otherwise has sufficient minimum contacts with the state of Missouri as more particularly described below. Defendant Group Health Plan has sufficient minimum contacts, and in fact, substantial contacts with Missouri such that the maintenance of this suit does not offend traditional notions of fair play and substantial justice. Defendant has voluntarily submitted itself to the jurisdiction of this Court and jurisdiction is proper because, among other things:

a. Defendant committed tortious acts within this state;

b. Plaintiffs' and the Class members' causes of action directly arise from the commission of tortious and unlawful acts in Missouri by Defendant:

c. Plaintiffs' and the Class members' causes of action directly arise from Defendant's transaction(s) of business in Missouri;

d. Defendant should reasonably anticipate being haled into court in Missouri to answer for its unlawful acts. Missouri has a strong interest in providing a forum for its residents aggrieved by violations of the law.

15. Venue is proper in this Circuit pursuant to RSMo § 508.010 in that a substantial part of the events giving rise to the claim occurred in within this Circuit.

PARTIES

Plaintiff

16. Plaintiff Jodie Nevils currently resides in Saint Louis County, Missouri.

Defendant

17. Defendant Group Health Plan is a private health insurance provider. Group Health Plan is organized under the laws of Missouri and is authorized to do business in the Sate of Missouri.

ALLEGATIONS COMMON TO ALL COUNTS

18. On or about November 2, 2006, representative Plaintiff Jodie Nevils was injured in a motor vehicle accident.

19. Plaintiff Nevils received treatment for his injuries sustained in the accident from numerous healthcare providers.

20. Plaintiff Nevils asserted a personal injury claim against the driver tortfeasor for his injuries sustained in the November 2, 2006 accident.

21. Plaintiff Nevils reached a settlement with the tortfeasor, paid through the tortfeasor's auto in-

surance policy, in compensation for his injuries, medical treatment, and pain and suffering, sustained in the accident.

22. Plaintiff Nevils was entitled to medical insurance coverage through a federal health benefit plan. The health plan that covers Plaintiff is governed by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 ("FEHBA").

23. The federal government has contracted with Defendant Group Health Plan to act as a "carrier" under FEHBA to provide health benefits and administer the subsidized healthcare plan provided under FEHBA to enrollees such as Ms. Nevils.

24. Plaintiff Nevils' medical bills related to the auto accident were paid by Defendant Group Health Plan.

25. Defendant Group Health Plan unlawfully asserted a lien in the amount of $6,592.24 for healthcare benefits and services provided to Mr. Nevils in treatment of his accident related injuries.

26. The United States Supreme Court held in *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677 (2006) that FEHBA's preemption clause — 5 U.S.C. § 8902(m)(1) — does not apply to subrogation or reimbursement rights of an insurer. Therefore, Missouri state law applies to the reimbursement rights of an insurer.

27. Missouri law has long prohibited subrogation in personal injury claims and does not allow for reimbursement to health insurers for payments made for treatment received related to a personal injury. This prohibition on subrogation of personal injury claims exists even if there is a contractual provision

in the health benefit plan that purports to allow for such subrogation rights.

28. There is no Federal provision that provides a reimbursement/subrogation right to such medical benefits paid pursuant to a FEHBA plan. Accordingly, such reimbursement rights are controlled by Missouri law, which expressly prohibits subrogation of health care benefits paid in connection with personal injury settlements.

29. Upon information and belief, despite being aware and informed of their lack of entitlement to reimbursement, the Defendant continued to pursue payment of unlawful reimbursement from Plaintiff's personal injury settlement.

30. On or about, January 29, 2010, Mr. Nevils remitted $6,592.24 to Defendant by and through Defendant's agent, ACS Recovery.

31. Subsequently, Defendant converted the funds from Mr. Nevils' personal injury settlement.

CLASS ACTION ALLEGATIONS

32. This action is brought as a plaintiff class pursuant to Missouri Rule of Civil Procedure 52.08. Plaintiff brings this action on her own behalf and all others similarly situated, as representative of the following class.

> All Missouri residents who received health insurance coverage through a FEHBA plan, administered by Defendant Group Health Plan Inc., who have had a right of reimbursement asserted against a personal injury claim or settlement by Group Health Plan and/or its agents, contractors or other third parties acting on its behalf, and such reim-

bursement was paid to Defendant since within five years of the filing date of this Petition.

33. The particular members of the class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of the Defendant. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

34. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class members. The only material difference between the Class members' claims is the exact monetary amount to which each member of the Class is entitled. The principal common issues include, but are certainly not limited to the following:

(a) Whether Group Health Plan entered into express and/or implied agreements with the federal government providing for reimbursement/subrogation rights on personal injury claims;

(b) Whether a provision for reimbursement/subrogation rights on personal injury claims contained in such a statement of benefits would be unenforceable under Missouri law;

(c) Whether Defendant employs a policy and business model of unlawfully asserting reimburse-

ment/subrogation rights to which they are not entitled;

(d) Whether Defendant unlawfully asserted reimbursement/subrogation rights against personal injury claims/settlements in violation of Missouri law;

(e) Whether the Defendant utilized aggressive collection practices to collect reimbursement of funds from the Plaintiff and the Class to which they were not entitled under applicable law;

(f) Whether such uniform practices asserted against all class members were unlawful and, thereby, unjustly profited the Defendant at the Plaintiff's and the Class members' expense;

(g) Whether Defendant has been unjustly enriched at the Plaintiff's and the Class members' expense through the misconduct described herein;

(i) Whether Defendant violated the Missouri Merchandising Practices Act through the above described misconduct;

(k) Whether Defendant should be enjoined from continuing their unfair, predatory, and abusive conduct

35. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories.

36. Plaintiff will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel in complex class actions. Counsel is committed to the vigorous prosecution of this action.

37. Certification of a plaintiff class is appropriate in that Plaintiff and the Class members seek monetary damages, common questions predominate over any individual questions, and a plaintiff class action is superior for the fair and efficient adjudication of this controversy. A plaintiff class action will cause an orderly and expeditious administration of the Class members' claims and economies of time, effort and expense will be fostered and uniformity of decisions will be ensured. Moreover, the individual class members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against the likes of the Defendant.

38. Alternatively, certification of a plaintiff class is appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for the Defendant or adjudications with respect to individual members of the Class as a practical matter would be dispositive of the interests of the other members not parties to the adjudications or would substantially impair or impede their ability to protect their interests.

39. Defendant has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

COUNT I
(Violation of the Missouri Merchandising Practices Act)

40. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

41. RSMo. § 407.020 prohibits the use of any "deception, fraud, false pretense, false promise, misrepresentation, unfair practice or the concealment, suppression, or omission of any material fact in connection with the sale or advertisement of any merchandise in trade or commerce..."

42. An "unfair practice" is defined by Missouri law, 15 CSR 60-8.020, as any practice which:

(A) Either-

1. Offends any public policy as it has been established by the Constitution, statutes or common law of this state, or by the Federal Trade Commission, or its interpretive decisions; or

2. Is unethical, oppressive or unscrupulous; and

(B) Presents a risk of or causes, substantial injury to consumers.

43. An "unfair practice" is further defined by Missouri law, 15 CSR 60-8.040, accordingly:

(l) It is an unfair practice for any person in connection with the advertisement or sale of merchandise to violate the duty of good faith in solicitation, negotiation and performance, or in any manner fail to act in good faith.

44. "Merchandise" is defined by the MPA, at RSMo. § 407.010(4), to include the providing of "services" and, therefore, encompasses the providing for the administration of medical care and billing for the same:

45. "Person" is defined by the MPA, at RSMo. § 407.010(5), to include any "for-profit or not-for-

profit corporation...company...business entity or association, and any agent, employee, salesman, partner, officer, director, member, stockholder, associate, trustee or cestui que trust thereof."

46. The above described behavior, misconduct, and unlawful acts of the Defendant violate the Missouri Merchandising Practices Act by, among other things, constituting an unfair practice and breach of the duty of good faith as required under the Act.

47. As a result of the above described wrongful acts, Plaintiff and the Class members have suffered damages.

COUNT II
(Unjust Enrichment)

48. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

49. As alleged above, the Defendant has engaged in a pattern and practice of unlawfully subverting the financial interests of Plaintiff and the Class for their own pecuniary gain.

50. Defendant has been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled to and received in violation of Missouri law.

51. Said benefits were unlawfully obtained to the detriment of Plaintiff and the Class Members.

52. Allowing Defendant to retain the aforementioned benefits violates fundamental principles of justice, equity, and good conscience.

COUNT III
(Conversion)

53. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

54. As alleged above, Defendant has engaged in a pattern and practice of unlawfully depriving the Plaintiff and the Class of certain property.

55. Plaintiff and the Class were legally entitled to the property in question when the Defendant deprived Plaintiff of the property.

56. Defendant acted purposefully and wrongfully in dispossessing Plaintiff and the Class of the property in question.

57. Such unfair misconduct by Defendant caused economic injury and other damages to the Plaintiff and the Class.

COUNT IV
(Injunctive Relief)

58. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

59. As set forth herein, Defendant has improperly taken the property of Plaintiff and the Class Members for its own pecuniary benefit as prohibited by law.

60. Upon information and belief, Defendant continue the unlawful practices enumerated above causing irreparable harm to the Plaintiff and the Class members.

61. As set forth herein, Plaintiff and the Class have a high probability of success on the merits of this action.

62. Accordingly, Defendant should be enjoined from continuing to perpetuate such predatory and unfair practices on consumers, such as Plaintiff and the Class.

PRAYER FOR DAMAGES AND RELIEF

WHEREFORE, Plaintiff, on behalf of himself and all members of the Class respectfully prays for judgment against the Defendant as follows:

a) For an order certifying that this action may be maintained as a class action and appointing Plaintiff and his counsel, to represent the Class;

b) For a declaration that the Defendant's actions violated the Plaintiff's and the Class members' rights under Missouri law as plead herein;

c) For all actual damages, punitive damages, statutory damages, penalties, and remedies available for the Defendant's violations of Plaintiff's and the Class members' rights under Missouri law;

d) For a declaration that Defendant, through the actions and misconduct as alleged above, have been unjustly enriched and an order that Defendant disgorge any unlawfully gained proceeds;

e) For pre-judgment interest as provided by law;

f) For post-judgment interest as provided by law;

g) For a permanent injunction enjoining Defendant from engaging in the unlawful practices as enumerated above;

h) For an award to Plaintiff and the Class their reasonable attorneys' fees;

i) For an award to Plaintiff and the Class of their costs and expenses of this action;

j) For such other and further relief as the Court may deem necessary and proper.

Respectfully Submitted,

By: s/_____

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ATTORNEYS FOR PLAINTIFFS

AFFIDAVIT OF DAVID DICKSON
(Mo. Cir. Ct. Aug. 16, 2011)

I, David Dickson, declare as follows:

1. I am over the age of 18 years and competent to testify to the following facts, based upon my personal knowledge and knowledge gathered in the course of my employment.

2. I am employed as the Chief Financial and Compliance Officer of Group Health Plan, Inc. ("GHP").

3. In Missouri, GHP, through its vendor ACS Recovery Services, subrogates for at least one self-insured plan covered under the Employee Retirement Income Security Act of 1974 (ERISA).

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 16th day of August, 2011.

s/

STATE OF MISSOURI)
) SS.
COUNTY OF ST. LOUIS)

On this 16th day of August, 2011, before me personally appeared David Dickson, to me known to be the person described in and who executed the foregoing instrument, and acknowledged that he executed the same as his free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the City and State aforesaid, the day and year first above written.

s/
Notary Public

My Commission Expires:

September 24, 2013

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

COMMUNITY-RATED HEALTH MAINTENANCE ORGANIZATION CARRIERS

2006

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1930 AMENDMENT NO: 2006
EFFECTIVE: January 1, 2006 EFFECTIVE: January 1, 2006

BETWEEN: The United States Office of Personnel Management *hereinafter called OPM, the Agency, or the Government*

Address: 1900 E Street, NW
Washington, DC 20415-3640

AND

CONTRACTOR: GROUP HEALTH PLAN, INC.
hereinafter also called the Carrier

Address: 111 CORPORATE OFFICE DRIVE, SUITE 400
EARTH CITY, MO 63045

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
FRANK D'ANTONIO	WILLIAM T. STUART
Name of person authorized to execute contract *type or print*)	Name of Contracting Officer *type or print*)
VICE PRESIDENT, SALES & MARKETING Title	CONTRACTING OFFICER Title
s/ Signature	s/ Signature
11/2/05 Date signed	November 18, 2005 Date signed

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PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 1997)

For purpose of this contract, the following definitions apply:

FEHBP: Federal Employees Health Benefits Program.

Enrollee: The Federal employee, annuitant, former spouse, temporarily-covered former Federal employee or dependent, enrolled under this contract.

Member: The Enrollee and/or an eligible dependent for benefit purposes, and sometimes referred to as subscriber.

Act: The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.

Regulations: 1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) chapters 1 and 16 of title 48, Code of Federal Regulations.

Benefits: Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.

Carrier: As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

SECTION 1.2
ENTIRE CONTRACT (JAN 2003)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. All modifications to the contract must be made in writing to the duly authorized Contracting Officer.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this contract shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce any benefits under this contract or be used in the prosecution of or defense of a claim under this contract unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

SECTION 1.3
ORDER OF PRECEDENCE (JAN 1996)

Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in

chapters 1 and 16, title 48, Code of Federal Regulations, and this contract.

SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS
(JAN 2002)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890, title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the Contracting Officer will make an equitable adjustment in accordance with the changes clause, Section 5.38 – Changes—Negotiated Benefits Contracts.

SECTION 1.5
RECORDS AND INFORMATION TO BE
FURNISHED BY OPM (SEP 2000)

(a) OPM shall maintain or cause to be maintained records from which the Carrier may determine the names and social security numbers of all Enrollees. OPM, other agencies of the Federal Government, or the FEHB Clearinghouse shall furnish the information to the Carrier at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The OPM shall direct the agencies to provide the Carrier or the FEHB Clearinghouse, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium

paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government or the FEHB Clearinghouse.

(c) Clerical error (whether by OPM, any other Government agency, the FEHB Clearinghouse, or the Carrier) in keeping records pertaining to coverage under this contract, delays in making entries thereon, or failure to make or account for any deduction of enrollment charges, shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. If any person finds relevant facts pertaining to a person covered under this contract to be misstated, and if the misstatement affects the existence, amount, or extent of coverage, the actual facts shall determine whether coverage is in force under the terms of this contract.

SECTION 1.6
CONFIDENTIALITY OF RECORDS (JAN 1991)
(FEHBAR 1652.224-70)

(a) The Carrier shall use the personal data on employees and annuitants that is provided by agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the Federal Register as part of OPM's notice of systems of records.

(b) The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers confidential except as follows:

(1) As may be reasonably necessary for the administration of this contract;

(2) As authorized by the patient or his or her guardian;

(3) As disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged civil or criminal actions;

(4) As necessary to audit the contract;

(5) As necessary to carry out the coordination of benefit provisions of this contract; and

(6) For bona fide medical research or educational purposes. Release of information for medical research or educational purposes shall be limited to aggregated information of a statistical nature that does not identify any individual by name, social security number, or any other identifier unique to an individual.

(c) If the Carrier uses medical records for the administration of the contract, or for bona fide research or educational purposes, it shall so state in the Plan's brochure.

SECTION 1.7
STATISTICS AND SPECIAL STUDIES (JAN 2003)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies as instructed by OPM.

(d) The Carrier shall notify the OPM Contract Representative immediately upon a change in the name or address of the Carrier's contract administrator(s).

SECTION 1.8
NOTICE (JAN 2003)

Where the contract requires that notice be given to the other party, such notice must be given in writing to the address shown on this contract's signature page. To notify OPM, the Carrier must write to the Contracting Officer, unless otherwise specified.

SECTION 1.9
PLAN PERFORMANCE—COMMUNITY-RATED HMO CONTRACTS (JAN 2005)

(a) Detection of Fraud and Abuse. The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. The program must specify provisions in place for cost avoidance not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its fraud and abuse program. The Carrier must also submit annual reports to OPM by March 31 addressing the following: the number of cases; dollars identified as lost and recovered; actual and projected savings; cases referred by law enforcement and resolved through negotiated settlement; and number of arrests and

criminal convictions. The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Health Plan Employer Data and Information Set (HEDIS), or similar measures developed by accrediting organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

(1) Report to OPM on its current patient safety initiatives;

(2) Report to OPM on how it will strengthen its patient safety program for the future;

(3) Assist OPM in providing its members with consumer information and education regarding patient safety; and

(4) Work with its providers, independent accrediting organizations, and others to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality, cost-effective health care, if it has 500 or more Federal enrollees, the Carrier shall continue to pursue and maintain accreditation

according to the steps and timeframes outlined in the carrier's current business plan. The carrier shall submit accreditation changes and business plan updates to its OPM contract representative.

(e) Consumer Assessments of Health Plans Surveys (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the HEDIS Consumer Assessments of Health Plans Surveys (CAHPS) to provide feedback to enrollees on enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.7.

(f) Physician Credentialing. The Carrier is encouraged to use an independent accrediting organization to validate its physician credentialing. If the Carrier's physicians meet the credentialing requirements of the credentialing organization, it has met and exceeds the minimum requirements listed below. Otherwise, the Carrier must demonstrate that it requires the following credential checks of all of its physicians, both during the initial hiring process and during periodic re-credentialing. As an alternative, the Carrier may demonstrate that the following credential checks are performed by a secondary source, such as a hospital.

- Verification of medical school graduation records.
- Routine check with local and/or state medical societies and/or boards.

- Routine check of the Department of Health and Human Services (DHHS) list of debarred providers.
- Routine check of the National Practitioner Data Bank.

(g) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum, the Carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period.

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately divided by the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FMB claims must be processed accurately.

(2) *Coordination of Benefits (COB)* - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.

(3) *Claims Timeliness* - the average number of working days from the date the Carrier receives an FEHB claim to the date it adjudicates it (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD: The Carrier adjudicates 95 percent of claims within 30 working days.

(4) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the enrollee's agency or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier issues the ID card within fifteen calendar days after receiving the enrollment from the enrollee's agency or retirement system except that the Carrier will issue ID cards resulting from an open season election within fifteen calendar days or by December 15, whichever is later.

(5) *Member Inquiries* - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage, for the given time period.

REQUIRED STANDARD: The Carrier responds to 90 percent of inquiries within 15 working days (including internet inquiries).

(6) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. *Except that*, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) *Call Answer Timeliness* - the average number of seconds elapsing before the Carrier connects a member's telephone call to its service representative.

REQUIRED STANDARD: On average, no more than 30 seconds elapse before the Carrier connects a member's telephone call to its service representative.

(ii) *Telephone Blockage Rate* - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD: No more than 5% of callers receive a busy signal.

(iii) *Telephone Abandonment Rate* - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, enrollees abandon the effort no more than 5 percent of the time.

(iv) *Initial Call Resolution* - the percentage of issues resolved during the initial call.

REQUIRED STANDARD: On average, caller's issues must be resolved during the initial call at least 60% of the time.

(7) *Responsiveness to FEHB Member Requests for Reconsideration*:

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide the service, or request additional information reasonably necessary to make a determination.

(h) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(i) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(j) Correction of deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph (j) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(k) In order to allow sufficient implementation time, the Contracting Officer with notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (i).

SECTION 1.10
NOTICE OF SIGNIFICANT EVENTS[1] (JUL 2005)
(FEHBAR 1652.222.70)

(a) The Carrier agrees to notify the Contracting Officer of any Significant Event within ten (10) work-

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[1] In Section 1.10, 13d is not applicable to community-rated HMO contracts.

ing days after the Carrier becomes aware of it. As used in this section, a Significant Event is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the Carrier's ability to meet its obligations under this contract, including, but not limited to, any of the following:

(1) Disposal of major assets;

(2) Loss of 15% or more of the Carrier's overall membership;

(3) Termination or modification of any contract or subcontract if such termination or modification might have a material effect on the Carrier's obligations under this contract;

(4) Addition or termination of provider agreements;

(5) Any changes in underwriters, reinsurers or participating plans;

(6) The imposition of or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

(7) The withdrawal of, or notice of intent to withdraw State licensing, HHS qualification, or any other status under Federal or State law;

(8) Default on a loan or other financial obligation;

(9) Any actual or potential labor dispute that delays or threatens to delay timely performance or substantially impairs the functioning of the Carrier's facilities or facilities used by the Carrier in the performance of the contract;

(10)Any change in its charter, constitution, or by-laws which affects any provision of this contract or the Carrier's participation in the Federal Employees Health Benefits Program;

(11)Any significant changes in policies and procedures or interpretations of the contract or brochure which would affect the benefits available under the contract or the costs charged to the contract;

(12)Any fraud, embezzlement or misappropriation of FEHB funds; or

(13)Any written exceptions, reservations or qualifications expressed by the independent accounting firm (which ascribes to the standards of the American Institute of Certified Public Accountants) contracted with by the Carrier to provide an opinion on its annual financial statements.

(b) Upon learning of a Significant Event OPM may institute action, in proportion to the seriousness of the event, to protect the interest of Members, including, but not limited to--

(1) Directing the Carrier to take corrective action;

(2) Suspending new enrollments under this contract;

(3) Advising Enrollees of the Significant Event and providing them an opportunity to transfer to another plan;

(4) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account;

(5) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the Significant Event; or

(6) Terminating this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval.*

(c) Prior to taking action as described in paragraph (b) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(d) The Carrier will insert this clause in any subcontract or subcontract modification if the amount of the subcontract or modification charged to the FEHB Program (or in the case of a community-rated carrier, applicable to the FEHB Program) equals or exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7).

SECTION 1.11
FEHB 1NSPECTION[2] (JUL 2005) (FEHBAR 1652.246-70)

(a) The Contracting Officer, or an authorized representative of the Contracting Officer, has the right to inspect or evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unreasonably delay the work.

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[2] The references to Large Providers are not applicable to community-rated HMO contracts.

(b) The Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all books and records relating to the contract for purposes of the Contracting Officer's determination of the Carrier's subcontractor or Large Provider's compliance with the terms of the contract, including its payment (including rebate and other financial arrangements) and performance provisions. The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70. This subsection is applicable to subcontract and Large Provider Agreements with the exception of those that are subject to the "Audits and Records — Negotiation" clause, 48 CFR 52.215-2.

(c) If the Contracting Officer, or an authorized representative of the Contracting Officer, performs inspection, audit or evaluation on the premises of the Carrier, the subcontractor, or the Large Provider, the Carrier shall furnish or require the subcontractor or Large Provider to furnish all reasonable facilities for the safe and convenient performance of these duties.

(d) The Carrier shall insert this clause, including this subsection (d), in all subcontracts for underwriting and claim payments and administrative services and in all Large Provider Agreements and shall substitute "contractor", "Large Provider," or other appropriate reference for the term "Carrier."

SECTION 1.12
CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet its obligations under this contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or implementation of plans required under this Section, the OPM may institute action as it deems necessary to protect the interests of Members, including, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would he adversely affected by the deficiency.

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval*.

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate term for "Carrier."

SECTION 1.13
INFORMATION AND MARKETING MATERIALS
(JAN 2005)

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The Carrier bears full responsibility for the accuracy of its FEHB brochure, OPM, in its solo discretion, may order the Carrier to produce and distribute the agreed upon brochure text, in a format and quantity approved by OEM, including an electronic 508 compliant brochure version, Section 508 of the Rehabilitation Act of 1973, as amended 29 U.S.C. § 794d, for OPM's web site. This formatted document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure on a timely basis to all Federal employees, annuitants, former spouses and former employees and dependents enrolled in the Plan. The Carrier shall also distribute the document(s) to Federal agencies to be made available to such individuals who are eligible to enroll under this contract. At the direction of OPM, the Carrier shall produce and distribute an audio cassette version of the approved language. The Carrier may print additional FEHB brochures for distribution for its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in

accordance with FEHBAR 1652.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it is found to not conform to the agreed upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

SECTION 1.14
MISLEADING, DECEPTIVE OR UNFAIR ADVERTISING (JAN 1991) (FEHBAR 1652.203-70)

(a) The Carrier agrees that any advertising material including that labeled promotional material, marketing material, or supplemental literature, shall be truthful and not misleading.

(b) Criteria to assess compliance with paragraph (a) of this clause are available in the FEHB Supplemental Literature Guidelines which are developed by OPM and should be used, along with the additional guidelines set forth in FEHBAR 1603.702, as the primary guide in preparing material; further guidance is provided in the NAIC *Advertisements of Accident and Sickness Insurance Model Regulation*. The guidelines contained in this document are periodically updated and provided to the Carrier by OPM.

(c) Failure to conform to paragraph (a) of this clause may result in a reduction in the service charge, if appropriate, and corrective action to pro-

tect the interest of Federal Members. Corrective action will be appropriate to the circumstances and may include, but is not limited to the following actions by OPM:

(1) Directing the Carrier to cease and desist distribution, publication, or broadcast of the material;

(2) Directing the Carrier to issue corrections at the Carrier's expense arid in the same manner and media as the original material was made; and

(3) Directing the Carrier to provide, at the Carrier's expense, the correction in writing by certified mail to all enrollees of the Plan(s) that had been the subject of the original material;

(d) Egregious or repeated offenses may result in the following action by OPM:

(1) Suspending new enrollments in the Carrier's Plan(s);

(2) Providing Enrollees an opportunity to transfer to another plan; and

(3) Terminating the contract in accordance with Section 1.15, *Renewal and Withdrawal of Approval.*

(e) Prior to taking action as described in paragraphs (c) and (d) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(f) The Carrier shall incorporate this clause in subcontracts with its underwriter, if any, and other subcontractors directly involved in the preparation or distribution of such advertising material and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL
(JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to-

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

SECTION 1.16
[RESERVED]

SECTION 1.17
NOVATION AGREEMENT (JAN 1996)

The agreement at FEHBAR 1642.1204 shall be submitted for approval to OPM when the Carrier's assets or the entire portion of the assets pertinent' to

the performance of this contract, as determined by the Government, are transferred.

SECTION 1.18
AGREEMENT TO RECOGNIZE CARRIER'S CHANGE OF NAME (JAN 1996)

The agreement at FEHBAR 1642.1205 shall be submitted for approval to OPM when the Carrier changes its name and the Government's and Contractor's rights and obligations remain unaffected.

SECTION 1.19
CERTIFICATION UNDER P. L. 104-191 (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) (JAN 1998)

The Carrier will issue a certification of coverage for members in accordance with the regulations issued by the Department of Health and Human Services.

SECTION 1.20
PATIENTS' BILL OF RIGHTS (JAN 1999)

(a) The Carrier shall implement the recommendations in the Health Care Consumer Bill of Rights and Responsibilities ("Patients' Bill of Rights") in accordance with OPM guidance.

(b) During the Carrier's provider contract renewal process, the Carrier shall make any necessary modifications to such provider contracts to comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance. All new provider contracts with the Carrier shall comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance.

SECTION 1.21
ADMINISTRATIVE SIMPLIFICATION-HIPAA
(JAN 2003)

(a) The Carrier shall implement and be in compliance with the Department of Health and Human Services (DHHS) regulations regarding the standards for electronic transactions and code sets on the date DHHS specifies. The regulations at 45 CFR parts 160 and 162 are incorporated by reference in this contract.

(b) The Carrier shall implement and be in compliance with the DHHS regulations regarding the standards for privacy of individually identifiable health information on the date DHHS specifies. The regulations at 45 CFR parts 160 and 164 are incorporated by reference in this contract.

SECTION 1.22
HIPAA COMPLIANCE (JAN 1998)

(a) The Carrier shall comply with and shall take all steps reasonably necessary to ensure that its affiliates, subcontractors, and agents comply with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations. "Guaranteed availability" means the Carrier, affiliates, subcontractors, and agents do not engage in practices that: 1) decline to offer health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act "the Act") to, or deny enrollment of an eligible individual (as defined in section 2741(b) of the Act); or, 2) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(a) of the Act), with respect to such coverage.

(b) A State or Federal enforcement action as the result of noncompliance with the requirements of HIPAA is a significant event under Section 1.10 of this contrail, Notice of Significant Events. If the Carrier, or any affiliate, subcontractor, or agent, is notified of any enforcement action by any Federal or State authority with regard to HIPAA compliance, the Carrier must notify OPM within ten working days of learning of the action.

SECTION 1.23
NOTICE ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (HMO) (JAN 2003)

(a) Members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a carrier terminates (1) all or part of its FEBHP contract or (2) the members' specialty provider contract for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its members in writing of its intent to terminate all or part of its FEHBP contract, including service area reductions, or the members specialty provider contract, for reasons other than cause, in order to allow sufficient time for the members to arrange for continued care after the 90-day period or their postpartum care, whichever applies. The Carrier shall send the required notice to the member if the Carrier has in its records an address for the member different from the enrollee's address; otherwise, the Carrier may send the notice to the enrollee. The Carrier shall send the notice in time to ensure it is received by the members no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was pre-

vented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and the transitional care period run concurrently.

SECTION 1.24
TRANSITIONAL CARE (JAN 2003)

(a) "Transitional care" is specialized care provided for up to 90 days or through the postpartum period, whichever is later, to a member who is undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when the Carrier terminates (1) all or part of its FEHBP contract or (2) the member's specialty provider contract for reasons other than cause. The 90-day period begins the earlier of the date the member receives the notice required under Section 1.23, Notice on Termination of FEHBP or Provider Contract (HMO), or the date the Carrier's or the provider's contract ends.

(b) The Carrier shall ensure the following:

(1) If it terminates a part of its FEHB contract or a specialty provider contract other than for cause, it allows members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, whichever is later, under the same terms and conditions that existed at the beginning of the transitional care period; and (2) If it enrolls a new member who voluntarily changed carriers because the member's former carrier was no longer available in the FEHB Program, it provides transitional care for the member if he or she is undergoing treatment for a chronic or

disabling condition or is in the second or third trimester of pregnancy for up to 90 days, or through the postpartum period, whichever is later, under the same terms and conditions the member had under the prior carrier.

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to members;

(2) require the specialty provider to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient; and,

(3) require the specialty to give all necessary information to the Carrier for quality assurance purposes.

SECTION 1.25
DISCLOSURE NOTICE UNDER P.L. 108-173
(MEDICARE MODERNIZATION ACT OF 2003)
(JAN 2006)

The Carrier will issue, as part of its FEHB benefit's brochure, a disclosure notice concerning creditable prescription drug coverage in accordance with the regulation at 42 CFR §423.56 issued by the Department of Health and Human Services.

PART II - BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a

prerequisite to such enrollment, complete a Health Benefits Election Form or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) The Carrier shall, subject to the approval of the Contracting Officer, define an area from which it will accept enrollments. The Carrier may limit enrollment to individuals residing or employed inside the approved area.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any claim forms as necessary.

SECTION 2.2
BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited

by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each ease when the Carrier provides a benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shalt document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of services or supplies shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2003)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request; *provided*, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.11 *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) When members ore required to file claims for covered benefits, benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for receiving benefits and filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where

timely filing was prevented by administrative operations of Government or, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition. The examinations shall be made at the expense of the Carrier.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) When claim filing is required, benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and, when claim filing is required, may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and when claim filing is required, the Carrier may reimburse that person for any covered medical service or supply.

(4) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is

necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. §164.500 et seq.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments*. If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall--

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases to a collection attorney or a collection agency if the debt is not recovered.

(5) Make a prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved.

(7) Maintain records that document individual unrecovered erroneous pay nent collection activities for audit or future reference.

SECTION 2.4
TERMINATION OF COVERAGE AND
CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts, The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1998)

(a) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members, according to the following rules:

(1) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is permitted, and in which the Carrier subrogates for non-FEHB members;

(2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is prohibited, but in which the Carder subrogates for at least one plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(3) The Carrier shall not subrogate if it is doing business in a State that prohibits subrogation, and in which the Carrier does not subrogate for any plan covered under ERISA;

(4) For Carriers doing business in more than one State, the Carrier shall apply the rules in (1) through (3) of this subsection according to the rule applicable to the State in which the subrogation would take place.

(b) The Carrier's subrogation procedures and policies shall be shown in the agreed upon brochure text or made available to the enrollees upon request.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC *Group Coordination of Benefits*

Model Regulation, Rules for Coordination of Benefits, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC *Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits*, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term. *[NOTE: Subsection 2.6(b) will not be applied to this community-rated carrier. When there is double coverage for covered benefits, other than emergency services from non-Plan providers, the Health Maintenance Organization Carrier will continue to provide benefits in full, but will seek payment for the services and supplies provided, to the extent that the services and supplies are covered by the other coverage, no-fault automobile insurance or other primary plan. Likewise, Subsection 2.6(d) is not applicable to community-rated carriers.]*

SECTION 2.7
DEPARMENT AND OTHER SANCTIONS (JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the earlier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CPR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on

the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if

the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is noti-

fied that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may

make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
PROTECTION OF MEMBERS AGAINST
PROVIDER CLAIMS (JAN 1996)

(a) The Carrier shall provide the Contracting Officer with evidence that its contracts with providers (hospitals and physicians) contain a provision that, in the event of Carrier insolvency, or inability to pay expenses for any reason, the providers shall not look to Members for payment. The Carrier agrees that over 90 percent of the total benefit cost under this contract will be provided under such contracts with providers; or

(b) In lieu of subsection (a) above, the Contracting Officer may accept such other combinations of coverage which provide protection of Members against provider claims as defined in the NAIC (National Association of Insurance Commissioners) Model HMO Act, as amended; or

(c) The Carrier shall provide the Contracting Officer with documentation that it has such other appropriate combinations of coverage which would provide protection of Members against provider claims in the event of Currier insolvency, or inability to pay expenses for any reason.

(d) The Carrier shall notify the Contracting Officer as soon as it is aware that it will not be able to satisfy the requirements stated in subsections (a), (b), or (c) above.

SECTION 2.10
INDEPENDENT LABORATORIES (JAN 1991)

In order to assure a minimum standard of quality for laboratory services, the Carrier agrees that it will not use independent laboratories which do not comply with Medicare or similar standards.

SECTION 2.11
CLAIMS PROCESSING (JAN 2001)

A standardized claims filing process shall be used by all FEBH carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Centers for Medicare and Medicaid Services 1500 form or the UB-92 form;

(3) The Carrier shall not use any unique provider claim form(s) for FEHB member claims;

(4) The Carrier should reject all claims submitted on forms other than the CMS 1500 form or the UB-92 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.12
CALCULATION OF COST SEARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons.

SECTION 2.13
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2006)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A and Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments, and the balance between the Medicare approved amount and the Medicare limiting charge made by nonparticipating providers.

SECTION 2.14
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2004)

(a) The Carrier shalt fulfill all of the requirements agreed to under the contract that continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements extend beyond the date of the Carrier's termination until the effective date of the new enrollment including processing and paying claims incurred prior to the effective date of the new enrollment.

(c) When the prior carrier is discontinued in whole or in part, the gaining carrier assumes full coverage on the effective date of the new enrollment.

SECTION 2.15
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2006)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.

(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The Carrier may pay its benefits on retail pharmacy or mail order drugs eligible for Medicare Part B coverage.

PART III - PAYMENTS, CHARGES AND ACCOUNTING

SECTION 3.1
PAYMENTS (JAN 2003) (FEHBAR 1652.232-70)

(a) OPM will pay to the Carrier, in full settlement of its obligations under this contract, subject to adjustment for error or fraud, the subscription charges received for the Plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for the Contingency Reserve and for the administrative expenses of OPM, amounts assessed under FEHBAR 1609.7101-2, and amounts for obligations due pursuant to paragraph (b) of this clause, plus any payments made by OPM from the Contingency Reserve.

(b) OPM will notify the Carrier of amounts due for outstanding obligations under the contract. Not later than 60 days after the date of written notice from OPM, the Carrier shall reimburse OPM. If payment is not received within the prescribed time frame, OPM shall withhold the amount due from the subscription charges owed the Carrier under paragraph (a) of this clause.

(c) The specific subscription rates, charges, allowances and limitations applicable to the contract are set forth in Appendix B.

(d) Recurring payments from premiums shall be due and payable not later than thirty days after receipt by the Fund. The Contracting Officer may authorize special nonrecurring payments from the Contingency Reserve in accordance with OPM's regulations.

(e) In the event this contract between the Carrier and OPM is terminated or not renewed in accordance with General Provision 1.15, *Renewal and Withdrawal Approval*, the Contingency Reserve of the Carrier held by OPM shall be available to the Carrier to pay the necessary and proper charges against this contract to the extent that the reserves held by the Carrier are insufficient for that purpose.

[NOTE: The adjustment for error or fraud referenced in paragraph (a) and the necessary and proper charges against this contract if the contract is terminated or not renewed, referenced in subsection (d), shall be limited to the subscription rate and any contingency reserve payment otherwise provided for in this contract and shall not include claim charges or other expenses attributable to individual Members. Further, FEHBAR 1652.216-70, Accounting and Price Adjustment, applies if any adjustment to the contract price is determined.]

SECTION 3.2
ACCOUNTING AND PRICE ADJUSTMENT (JAN 2003) (FEHBAR 1652.216-70)

(a) *Annual Accounting Statement.* The Carrier, not later than 90 days after the end of each contract period, shall furnish to OPM for that contract period an accounting of its operations under the contract. The accounting shall be in the form prescribed by OPM.

(b) *Adjustment.* (1) This contract is community rated as defined in FEHBAR 1602.170-2.

(2) The subscription rates agreed to in this contract shall be equivalent to the subscription rates given to the Carrier's similarly sized subscriber groups (SSSGs) as defined in FEHBAR 1602.170-13.

(3) If, at the time of the rate reconciliation, the subscription rates are found to be lower than the equivalent rates for the lower of the two SSSGs, the Carrier may include an adjustment to the Federal group's rates for the next contract period.

(4) If, at the time of the rate reconciliation, the subscription rates are found to be higher than the equivalent rates for the lower of the two SSSGs, the Carrier shall reimburse the Fund, for example, by reducing the FEHB rates for the next contract term to reflect the difference between the estimated rates and the rates which are derived using the methodology of the lower rated SSSG.

(5) No upward adjustment in the rate established for this contract will be allowed or considered by the Government or will be made by the Carrier in this or in any other contract period on the basis of actual costs incurred, actual benefits provided, or actual size or composition of the FEHBP group during this contract period.

(6) In the event this contract is not renewed, neither the Government nor the Carrier shall be entitled to any adjustment or claim for the difference between the subscription rates prior to rate reconciliation and the actual subscription rates.

SECTION 3.3
RATE REDUCTION FOR DEFECTIVE PRICING OR DEFECTIVE COST OR PRICING DATA (JAN 2004) (FEHBAR 1652.215-70)

As prescribed in 1615.407-1, the following clause shall be inserted in FEHBP contracts exceeding the threshold at FAR 15.403-4(a)(1) that are based on a combination of cost and price analysis (community rated):

(a) If any rate established in connection with this contract was increased because (1) the Carrier-submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not complete, accurate, or current as certified in the Certificate of Accurate Cost or Pricing Data (FEHBAR 1615.406-2); (2) the Carrier submitted, or kept in its files in support of the FEHBP rate, cost or pricing data that were not accurate as represented in the rate proposal documents; (3) the Carrier developed FEHBP rates with a rating methodology and structure inconsistent with that used to develop rates for similarly sized subscriber groups (see FEHBAR §1602.170-13) as certified in the Certificate of Accurate Cost or Pricing Data for Community Rated Carriers; or (4) the Carrier submitted or kept in its files in support of the FEHBP rate, data or information of any description that were not complete, accurate, and current—then, the rate shall be reduced in the amount by which the price was increased because of the defective data or information.

(b)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Carrier agrees not to raise the following matters as a defense:

(i) The Carrier was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current cost or pricing data had been submitted or maintained and identified.

(ii) The Contracting Officer should have known that the cost or pricing data in issue were defective even though the Carrier took no affirmative action to

bring the character of the data to the attention of the Contracting Officer.

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract.

(iv) The Carrier did not submit or keep in its files a Certificate of Current Cost or Pricing Data.

(2)(i) Except as prohibited by subdivision (b)(2)(ii) of this clause, an offset in an amount determined appropriate by the Contracting Officer based upon the facts shall be allowed against the amount of a contract price reduction if--

(A) The Carrier certifies to the Contracting Officer that, to the best of the Carrier's knowledge and belief, the Carrier is entitled to the offset in the amount requested; and

(B) The Carrier proves that the cost or pricing data were available before the date of agreement on the price of the contract (or price of the modification) and that the data were not submitted before such date.

(ii) An offset shall not be allowed if—

(A) The understated data was known by the Carrier to be understated when the Certificate of Current Cost or Pricing Data was signed; or

(B) The Government proves that the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the date of agreement on price.

(c) When the Contracting Officer determines that the rates shall be reduced and the Government

is thereby entitled to a refund, the Carrier shall be liable to and shall pay the FEHB Fund at the time the overpayment is repaid-

(1) Simple interest on the amount of the overpayment from the date the overpayment was paid from the FEHB Fund to the Carrier until the date the overcharge is liquidated. In calculating the amount of interest due, the Carrier shall use the quarterly rate determinations by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods the overcharge was retained by the Carrier shall be used; and,

(2) A penalty equal to the amount of overpayment, if the Carrier knowingly submitted cost or pricing data which was incomplete, inaccurate, or noncurrent.

SECTION 3.4
CONTRACTOR RECORDS RETENTION (JUL 2005) (FEHBAR 1652.204-70)

Notwithstanding the provisions of Section 5.7 (FAR 52.215-2(f)) *Audit and Records Negotiation* the Carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that equal or exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of six years after the end of the contract term to which the records relate. This includes all records of Large Provider Agreements and subcontracts that equal or exceed the threshold requirements. In addition, individual enrollee and/or patient claim records will be maintained for six years after the end of the contract term to which the claim records relate. This clause is effective prospectively as of the 2005 contract year.

SECTION 3.5
APPROVAL FOR ASSIGNMENT OF CLAIMS (JAN 1991) (FEHBAR 1652.232-73)

(a) Notwithstanding the provisions of Section 5.35 [FAR 52.232-23], *Assignment of Claims*, the Carrier shall not make any assignment under the Assignment of Claims Act without the prior written approval of the Contracting Officer.

(b) Unless a different period is specified in the Contracting Officer's written approval, an assignment shall be in force only for a period of one year from the date of the Contracting Officer's approval. However, assignments may be renewed upon their expiration.

SECTION 3.6
DISCREPANCIES BETWEEN ENROLLMENT AND PAYMENTS TO CARRIER (JAN 2002)

(a) The OPM and the Carrier recognize that the portion of subscription payments under Section 3.1(a) forwarded by OPM to the Carrier for Enrollees may not be consistent with the Carrier's reconciliation of enrollment under Section 1.5. Therefore, the OPM and the Carrier agree:

(1) That any individual discrepancies discovered in the course of reconciliation, in which the agency certifying officer and the Carrier agree as to the enrollment status of the individual, shall be corrected by the applicable agency to reflect the valid enrollment(s). If the reconciliation indicates that the subscription payments were not made or were made in error, appropriate adjustments shall be made by the agency to the Fund pursuant to law. Any adjustment in the subscription charges received by the

Fund from the agency as a result of a reconciliation shall be forwarded by OEM under Section 3.1(a); and

(2) That the rates in Appendix B include an adjustment to the subscription charges equal to one percent in full resolution of all discrepancies not corrected under Section 3.6(b)(1).

(b) In consideration of the adjustments in Section 3.6(a)(1) and (2), the Carrier accepts the adjustment to the subscription charges in full resolution of all obligations of the Government in connection with the subscription payments as described in this section 3.6, and waives any rights it may have to claims for subscription payments under Section 3.1(a).

(c)(1) The FEHB Clearinghouse will facilitate the reconciliation of enrollments between carriers and Federal agencies. The Carrier shall pay a pro rata share based on its proportion of FEHB premiums as determined by OPM for the cost of developing the Clearinghouse.

(2) OEM shall withhold the amount due from the Carrier's subscription charges under the authority of FEHBAR 1652.232-70, Payments—Community-Rated Contracts, and shall forward payment to the FEHB Clearinghouse.

SECTION 3.7
SURVEY CHARGES (JAN 2002)

(a) If the Carrier participates in an FEHB annual consumer assessment survey, it shall pay OPM's contractor a pro rata share of the total cost of consolidating and reporting the survey results to OPM. The Carrier shall pay a separate fee for each plan option and/or rating area. The Carrier agrees to pay the contractor's invoice within 30 days of the billing date. If the Carrier does not remit payment to the

contractor within 60 days of the billing date, OPM shall withhold the amount due from the Carrier's subscription charges according to FEHBAR 1652.232-70, Payments—community-rated contracts, and forward payment to the contractor.

(b) Costs incurred by the Carrier for contracting with a vendor to conduct the survey shall be the Carrier's responsibility.

SECTION 3.8
TAXPAYER IDENTIFICATION NUMBER (JAN 2000) (FEHBAR 1652.204-73)

(a) *Definitions.*

"Common parent," as used in this provision, means that corporate entity that owns or controls an affiliated group of corporations that files its Federal income tax returns on a consolidated basis, and of which the Carrier is a member.

"Taxpayer Identification Number (TIN)," as used in this provision, means the number required by the Internal Revenue Service (IRS) to be used by the Carrier in reporting income tax and other returns.

(b) The Carrier must submit the information required in paragraphs (d) through (f) of this clause to comply with debt collection requirements of 31 U.S.C. 7701(c) and 3325(d), reporting requirements of 26 U.S.C. 6041, 6041A, and 6050M, and implementing regulations issued by the IRS. The Carrier is subject to the payment reporting requirements described in Federal Acquisition Regulation (FAR) 4,904. The Carrier's failure or refusal to furnish the information will result in payment being withheld until the TIN number is provided.

(c) The Government may use the TIN to collect and report on any delinquent amounts arising out of the Carrier's relationship with the Government (31 U.S.C. 7701(c)(3)). The TIN provided hereunder may be matched with IRS records to verify its accuracy.

(d) *Taxpayer Identification Number (TIN).*

TIN: *[redacted]*-2307

(e) Type of organization.

☐ Sole proprietorship;
☐ Partnership;
✓ Corporate entity (not tax-exempt);
☐ Corporate entity (tax-exempt);
☐ Other _____

(f) Common parent.

☐ Carrier is not owned or controlled by a common parent as defined in paragraph (a) of this clause.
☐ Name and TIN of common parent;

Name Coventry Health Care
TIN _____

(End of Clause)

SECTION 3.9
HIGH DEDUCTIBLE HEALTH PLANS (HDHP) WITH SIMILARLY SIZED SUBSCRIBER GROUPS (SSSGS)

If separate SSSGs are needed for a High Deductible Health Plan (FIDHP) because it is rated separately from the Carrier's traditional HMO's or the Carrier has no other plans in that region, the two SSSGs will be chosen based on size. If the Carrier's HDHPs are rated Adjusted Community Rated (ACR) and the groups closest in size are rated differently, that will be acceptable if that is the Carrier's current policy and it is done in a consistent matter. All other

rules for choosing SSSGs, will be consistent with the current rules for choosing SSSGs for traditional plans. If either of the SSSGs is given a discount, that discount should only be passed to the insurance portion and not the pass through.

PART IV -- SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2003) (FAR 52.252.4)

Portions of this contract are altered as follows:

(--) Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity,

(--) Section 1.14, *Misleading, Deceptive, or Unfair Advertising*, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carriers should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.702.

(--) Section 5.58. The reference to Central Contractor Registration in FAR 52.232-33, Payment by

Electronic Funds Transfer-Central Contractor Registration, is not applicable to this contract.

PART V - REQUIRED CLAUSES

SECTION 5.1
DEFINITIONS (JULY 2004) (FAR 52.202-1)

(a) When a solicitation provision or contract clause uses a word or term that is defined in the Federal Acquisition Regulation (FAR), the word or term has the same meaning as the definition in FAR 2.101 in effect at the time the solicitation was issued, unless--

(1) The solicitation or amended solicitation provides a different definition;

(2) The contracting parties agree to a different definition;

(3) The part, subpart, or section of the FAR where the provision or clause is prescribed provides a different meaning; or

(4) The word or term is defined in FAR Part 31, for use in the cost principles and procedures.

(b) The FAR index is a guide to words and terms the FAR defines and shows where each definition is located. The FAR Index is available via the Internet at http://www.acqnet.gov at the end of the FAR, after the FAR Appendix.

SECTION 5.2
[RESERVED]

SECTION 5.3
GRATUITIES (APR 1984) (FAR 52.203-3)

(a) The right of the Contractor to proceed may be terminated by written notice if, after notice and hearing, the agency head or a designee determines that the Contractor, its agent, or another representative -

(1) Offered or gave a gratuity (e.g., an entertainment or gift) to an officer, official, or employee of the Government; and

(2) Intended, by the gratuity, to obtain a contractor favorable treatment under a contract.

(b) The facts supporting this determination may be reviewed by any court having lawful jurisdiction.

(c) If this contract is terminated under paragraph (a) above, the Government is entitled -- (1) To pursue the same remedies as in a breach of the contract; and (2) In addition to any other damages provided by law, to exemplary damages of not less than 3 nor more than 10 times the cost incurred by the Contractor in giving gratuities to the person concerned, as determined by the agency head or a designee. (This subparagraph (c)(2) is applicable only if this contract uses money appropriated to the Department of Defense.)

(d) The rights and remedies of the Government provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.4
COVENANT AGAINST CONTINGENT FEES (APR 1984) (FAR 52.203-5)

(a) The Contractor warrants that no person or agency has been employed or retained to solicit or obtain this contract upon an agreement or understanding for a contingent fee, except a bona fide employee or agency. For breach or violation of this warranty, the Government shall have the right to annul this contract without liability or, in its discretion, to deduct from the contract price or consideration, or otherwise recover, the full amount of the contingent fee.

(b) "Bona fide agency," as used in this clause, means an established commercial or selling agency, maintained by a contractor for the purpose of securing business, that neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds itself out as being able to obtain any Government contract or contracts through improper influence. "Bona fide employee," as used in this clause, means a person, employed by a contractor and subject to the contractor's supervision and control as to time, place, and manner of performance, who neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds out as being able to obtain any Government contract or contracts through improper influence. "Contingent fee", as used in this clause, means any commission, percentage, brokerage, or other fee that is contingent upon the success that a person or concern has in securing a Government contract. "Improper influence," as used in this clause, means any influence that induces or tends to induce a Government employee or officer to give considera-

tion or to act regarding a Government contract on any basis other than the merits of the matter.

SECTION 5.5
ANTI-KICKBACK PROCEDURES (JUL 1995) (FAR 52.203-7)

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor," as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) The Anti-Kickback Act of 1986 (41 U.S.C. 51-58) (the Act), prohibits any person from--

(1) Providing or attempting to provide or offering to provide any kickback;

(2) Soliciting, accepting, or attempting to accept any kickback; or

(3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation, Such reports shall be made to the inspector

general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Department of Justice.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold, from sums owed a subcontractor under the prime contract, the amount of any kickback. The Contracting Officer may order the monies withheld under subdivision (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause, In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including this subparagraph (c)(5) but excepting subparagraph (c)(1), in all subcontracts under this contract which exceed $100,000.

SECTION 5.6
[RESERVED]

SECTION 5.7
AUDIT AND RECORDS-NEGOTIATION (JUN 1999) (FAR 52.215-2)

(a) As used in this clause, "records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.

(b) *Examination of costs.* If this is a cost- reimbursement, incentive, time-and-materials, labor-hour or price redeterminable contract, or any combination of these, the Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all records and other evidence sufficient to reflect properly all costs claimed to have been incurred or anticipated to be incurred directly or indirectly in performance of this contract. This right of examination shall include inspection at all reasonable times of the Contractor's plants, or parts of them, engaged in performing the contract.

(c) *Cost or pricing data.* If the Contractor has been required to submit cost or pricing data in connection with any pricing action relating to this contract, the Contracting Officer, or an authorized representative of the Contracting Officer, in order to evaluate the accuracy, completeness, and currency of the cost or pricing data, shall have the right to examine and audit all of the Contractor's records, including computations and projections, related to--

(1) The proposal for the contract, subcontract, or modification;

(2) The discussions conducted on the proposal(s), including those related to negotiating;

(3) Pricing of the contract, subcontract, or modification; or

(4) Performance of the contract, subcontract or modification.

(d) *Comptroller General* — (1) The Comptroller General of the United States, or an authorized representative, shall have access to and the right to examine any of the Contractor's directly pertinent records

involving transactions related to this contract or a subcontract hereunder.

(2) This paragraph may not be construed to require the Contractor or subcontractor to create or maintain any record that the Contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e) *Reports.* If the Contractor is required to furnish cost, funding, or performance reports, the Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating (i) The effectiveness of the Contractor's policies and procedures to produce data compatible with the objectives of these reports and (2) The data reported.

(f) *Availability.* The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract. In addition—(1) If this contract is completely or partially terminated, the Contractor shall make available the records relating to the work terminated until 3 years after any resulting final termination settlement; and (2) The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.

(g) The Contractor shall insert a clause containing all the terms of this clause, including this paragraph (g), in all subcontracts under this contract that exceed the simplified acquisition threshold and--

(1) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;

(2) For which cost or pricing data are required; or

(3) That require the subcontractor to furnish reports as discussed in paragraph (e) of this clause. The clause may be altered only as necessary to identify properly the contracting parties and the Contracting Officer under the Government prime contract.

SECTION 5.8 THRU 5.13
[RESERVED]

SECTION 5.14
UTILIZATION OF SMALL BUSINESS CONCERNS[1] (MAY 2004) (FAR 52.219-8)

(a) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for ma-

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[1] Section 5.14 only applies to six plans participating in the small business pilot (none are experience-rated HMOs).

jor systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(b) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(c) *Definitions.* As used in this contract--"HUBZone small business concern" means a small business concern that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration. "Service-disabled veteran-owned small business concern"—

(1) Means a small business concern-

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a veteran with

permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C, 101(16).

"Small business concern" means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

"Small disadvantaged business concern" means a small business concern that represents, as part of its offer that--

(1) It has received certification as a small disadvantaged business concern consistent with 13 CFR part 124, Subpart B;

(2) No material change in disadvantaged ownership and control has occurred since its certification;

(3) Where the concern is owned by one or more individuals, the net worth of each individual upon whom the certification is based does not exceed $750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(4) It is identified, on the date of its representation, as a certified small disadvantaged business in the database maintained by the Small Business Administration (PRO-Net).

"Veteran-owned small business concern" means a small business concern--

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not

less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

"Women-owned small business concern" means a small business concern--

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(d) Contractors acting in good faith may rely on written representations by their subcontractors regarding their status as a small business concern, a veteran-owned small business concern, a service-disabled veteran-owned small business concern, a HUBZone small business concern, a small disadvantaged business concern, or a women-owned small business concern.

SECTION 5.15 THRU 5.16
[RESERVED]

SECTION 5.17
CONVICT LABOR (JUN 2003) (FAR 52.222-3)

(a) Except as provided in paragraph (b) of this clause, the Contractor shall not employ in the performance of this contract any person undergoing a sentence of imprisonment imposed by any court of a State, the District of Columbia, Puerto Rico, the Northern Mariana islands, American Samoa, Guam, or the U.S. Virgin Islands.

(b) The Contractor is not prohibited from employing persons-

(1) On parole or probation to work at paid employment during the term of their sentence;

(2) Who have been pardoned or who have served their terms; or

(3) Confined for violation of the laws of any of the States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, or the U.S. Virgin Islands who are authorized to work at paid employment in the community under the laws of such jurisdiction, if-

(i) The worker is paid or is in an approved work training program on a voluntary basis;

(ii) Representatives of local union central bodies or similar labor union organizations have been consulted;

(iii) Such paid employment will not result in the displacement of employed workers, or be applied in skills, crafts, or trades in which there is a surplus of available gainful labor in the locality, or impair existing contracts for services;

(iv) The rates of pay and other conditions of employment will not be less than those paid or provided for work of a similar nature in the locality in which the work is being performed; and

(v) The Attorney General of the United States has certified that the work-release laws or regulations of the jurisdiction involved are in conformity with the requirements of Executive Order 11755, as amended by Executive Orders 12608 and 12943.

SECTION 5.18
CONTRACT WORK HOURS AND SAFETY STANDARDS ACT - OVERTIME COMPENSATION (JUL 2005) (FAR 52.222-4)

(a) *Overtime requirements.* No Contractor or subcontractor employing laborers or mechanics (see Federal Acquisition Regulation 22.300) shall require or permit them to work over 40 hours in any workweek unless they are paid at least 1 and 1/2 times the basic rate of pay for each hour worked over 40 hours.

(b) *Violation: liability for unpaid wages; liquidated damages.* The responsible Contractor and subcontractor are liable for unpaid wages if they violate the terms in paragraph (a) of this clause. In addition, the Contractor and subcontractor are liable for liquidated damages payable to the Government. The Contracting Officer will assess liquidated damages at the rate of $10 per affected employee for each calendar day on which the employer required or permitted the employee to work in excess of the standard workweek of 40 hours without paying overtime wages required by the Contract Work Hours and Safety Standards Act.

(c) *Withholding for unpaid wages and liquidated damages.* The Contracting Officer will withhold from payments due under the contract sufficient funds required to satisfy any Contractor or subcontractor liabilities for unpaid wages and liquidated damages. If amounts withheld under the contract are insufficient to satisfy Contractor or subcontractor liabilities, the Contracting Officer will withhold payments from other Federal or Federally assisted contracts held by the same Contractor that are sub-

ject to the Contract work Hours and Safety Standards Act.

(d) Payrolls and basic records. (1) The Contractor and its subcontractors shall maintain payrolls and basic payroll records for all laborers and mechanics working on the contract during the contract and shall make them available to the Government until 3 years after contract completion. The records shall contain the name and address of each employee, social security number, labor classifications, hourly rates of wages paid, daily and weekly number of hours worked, deductions made, and actual wages paid. The records need not duplicate those required for construction work by Department of Labor regulations at 29 CFR 5.5(a)(3) implementing the Davis-Bacon Act.

(2) The Contractor and its subcontractors shall allow authorized representatives of the Contracting Officer or the Department of Labor to inspect, copy, or transcribe records maintained under paragraph (d)(1) of this clause. The Contractor or subcontractor also shall allow authorized representatives of the Contracting Officer or Department of Labor to interview employees in the workplace during working hours.

(e) Subcontracts. The Contractor shall insert the provisions set forth in paragraphs (a) through (d) of this clause in subcontracts that may require or involve the employment of laborers and mechanics and require subcontractors to include these provisions in any such lower tier subcontracts. The Contractor shall be responsible for compliance by any subcontractor or lower-tier subcontractor with the provisions set forth in paragraphs (a) through (d) of this clause.

SECTION 5.19
EQUAL OPPORTUNITY (APR 2002) (FAR 52.222-26)

(a) Definition. United States, us used in this clause, means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b) If, during any 12-month period (including the 12 months preceding the award of this contract), the Contractor has been or is awarded nonexempt Federal contracts and/or subcontracts that have an aggregate value in excess of $10,000, the Contractor shall comply with subparagraphs (b)(1) through (b)(11) of this clause, except for work performed outside the United States by employees who were not recruited within the United States, Upon request, the Contractor shall provide information necessary to determine the applicability of this clause.

(1) The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. However, it shall not be a violation of this clause for the Contractor to extend a publicly announced preference in employment to Indians living on or near an Indian reservation, in connection with employment opportunities on or near an Indian reservation, as permitted by 41 CFR 60-1.5.

(2) The Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, or national origin. This shall include, but not be limited to--

(i) Employment;

(ii) Upgrading;

(iii) Demotion;

(iv) Transfer;

(v) Recruitment or recruitment advertising;

(vi) Layoff or termination;

(vii) Rates of pay or other forms of compensation; and

(viii) Selection for training, including apprenticeship.

(3) The Contractor shall post in conspicuous places available to employees and applicants for employment the notices to be provided by the Contracting Officer that explain this clause.

(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, or national origin.

(5) The Contractor shall send, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, the notice to be provided by the Contracting Officer advising the labor union or workers' representative of the Contractor's commitments under this clause, and post copies of the notice in conspicuous places available to employees and applicants for employment.

(6) The Contractor shall comply with Executive Order 11246, as amended, and the rules, regulations, and orders of the Secretary of Labor.

(7) The Contractor shall furnish to the contracting agency all information required by Executive Order 11246, as amended, and by the rules, regulations, and orders of the Secretary of Labor. The Contractor shall also file Standard Form 100 (EEO-1), or any successor forms as prescribed in 41 CFR part 60-1. Unless the Contractor has filed within the 12 months preceding the date of contract award, the Contractor shall, within 30 days after contract award, apply to either the regional Office of Federal Contract Compliance Programs (OFCCP) or the local office of the Equal Employment Opportunity Commission for the necessary forms.

(8) The Contractor shall permit access to its premises, during normal business hours, by the contracting agency or the OFCCP for the purpose of conducting on-site compliance evaluations and complaint investigations. The Contractor shall permit the Government to inspect and copy any books, accounts, records (including computerized records), and other material that may be relevant to the matter under investigation and pertinent to compliance with Executive Order 11246, as amended, and rules and regulations that implement the Executive Order.

(9) If the OFCCP) determines that the Contractor is not in compliance with this clause or any rule, regulation., or order of the Secretary of Labor, this contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts, under the procedures authorized in Executive Order 11246, as amended. In addition, sanctions may be imposed and remedies invoked against the Contractor as provided in Executive Order 11246, as amend-

ed; in the rules, regulations, and orders of the Secretary of Labor; or as otherwise provided by law.

(10)The Contractor shall include the terms and conditions of subparagraphs (b)(1) through (11) of this clause in every subcontract or purchase order that is not exempted by the rules, regulations, or orders of the Secretary of Labor issued under Executive Order 11246, as amended, so that these terms and conditions will be binding upon each subcontractor or vendor.

(11)The Contractor shall take such action with respect to any subcontract or purchase order as the Contracting Officer may direct as a means of enforcing these terms and conditions, including sanctions for noncompliance, provided, that if the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of any direction, the Contractor may request the United States to enter into the litigation to protect the interests of the United States.

(c) Notwithstanding any other clause in this contract, disputes relative to this clause will be governed by the procedures in 41 CFR 60-1.1.

SECTION 5.20
[RESERVED]

SECTION 5.21
NOTIFICATION OF VISA DENIAL (JUN 2003)
(FAR 52.222-29)

It is a violation of Executive Order 11246 for a Contractor to refuse to employ any applicant or not to assign any person hired in the United States, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, or Wake Island, on the basis that the individual's race, color,

religion, sex, or national origin is not compatible with the policies of the country where or for whom the work will be performed (41 CFR 60-1.10). The Contractor shall notify the U.S. Department of State, Assistant Secretary, Bureau of Political-Military Affairs (PM), 2201 C Street NW, Room 6212, Washington, DC 20520, and the U.S. Department of Labor, Deputy Assistant Secretary for Federal Contract Compliance, when it has knowledge of any employee or potential employee being denied an entry visa to a country where this contract will be performed, and it believes the denial is attributable to the race, color, religion, sex, or national origin of the employee or potential employee.

SECTION 5.22
EQUAL OPPORTUNITY FOR SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (DEC 2001) (FAR 52.222-35)

(a) *Definitions.* As used in this clause—

"All employment openings" means all positions except executive and top management, those positions that will be filled from within the Contractor's organization, and positions lasting 3 days or less. This term includes full-time employment, temporary employment of more than 3 days duration, and part-time employment.

"Executive and top management" means any employee—

(1) Whose primary duty consists of the management of the enterprise in which the individual is employed or of a customarily recognized department or subdivision thereof;

(2) Who customarily and regularly directs the work of two or more other employees;

(3) Who has the authority to hire or fire other employees or whose suggestions and recommendations as to the hiring or firing and as to the advancement and promotion or any other change of status of other employees will be given particular weight;

(4) Who customarily and regularly exercises discretionary powers; and

(5) Who does not devote more than 20 percent or, in the case of an employee of a retail or service establishment, who does not devote more than 40 percent of total hours of work in the work week to activities that are not directly and closely related to the performance of the work described in paragraphs (1) through (4) of this definition. This paragraph (5) does not apply in the case of an employee who is in sole charge of an establishment or a physically separated branch establishment, or who owns at least a 20 percent interest in the enterprise in which the individual is employed.

"Other eligible veteran" means any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized.

"Positions that will be filled from within the Contractor's organization" means employment openings for which the Contractor will give no consideration to persons outside the Contractor's organization (including any affiliates, subsidiaries, and parent companies) and includes any openings the Contractor proposes to fill from regularly established "recall" lists. The exception does not apply to a particular

opening once an employer decides to consider applicants outside of its organization.

"Qualified special disabled veteran" means a special disabled veteran who satisfies the requisite skill, experience, education, and other job-related requirements of the employment position such veteran holds or desires, and who, with or without reasonable accommodation, can perform the essential functions of such position.

"Special disabled veteran" means—

(1) A veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Department of Veterans Affairs for a disability—

(i) Rated at 30 percent or more; or

(ii) Rated at 10 or 20 percent in the case of a veteran who has been determined under 38 U.S.C. 3106 to have a serious employment handicap (i.e., a significant impairment of the veteran's ability to prepare for, obtain, or retain employment consistent with the veteran's abilities, aptitudes, and interests); or

(2) A person who was discharged or released from active duty because of a service-connected disability.

"Veteran of the Vietnam era" means a person who

(1) Served on active duty for a period of more than 180 days and was discharged or released from active duty with other than a dishonorable discharge, if any part of such active duty occurred—

(i) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or

(ii) Between August 5, 1964, and May 7, 1975, in all other cases; or

(2) Was discharged or released from active duty for a service-connected disability if any part of the active duty was performed—

(i) In the Republic of Vietnam between February 28, 1961, and May 7, 1975; or

(ii) Between August 5, 1964, and May 7, 1975, in all other cases.

(b) *General.* (1) The Contractor shall not discriminate against the individual because the individual is a special disabled veteran, a veteran of the Vietnam era, or other eligible veteran, regarding any position for which the employee or applicant for employment is qualified, The Contractor shall take affirmative action to employ, advance in employment, and otherwise treat qualified special disabled veterans, veterans of the Vietnam era, and other eligible veterans without discrimination based upon their disability or veterans' status in all employment practices such as—

(i) Recruitment, advertising, and job application procedures;

(ii) Hiring, upgrading, promotion, award of tenure, demotion, transfer, layoff, termination, right of return from layoff and rehiring;

(iii) Rate of pay or any other form of compensation and changes in compensation;

(iv) Job assignments, job classifications, organizational structures, position descriptions, lines of progression, and seniority lists;

(v) Leaves of absence, sick leave, or any other leave;

(vi) Fringe benefits available by virtue of employment, whether or not administered by the Contractor;

(vii) Selection and financial support for training, including apprenticeship, and on-the-job training under 38 U.S.C. 3687, professional meetings, conferences, and other related activities, and selection for leaves of absence to pursue training;

(viii) Activities sponsored by the Contractor including social or recreational programs; and

(ix) Any other term, condition, or privilege of employment.

(2) The Contractor shall comply with the rules, regulations, and relevant orders of the Secretary of Labor issued under the Vietnam Era Veterans' Readjustment Assistance Act of 1972 (the Act), as amended (38 U.S.C. 4211 and 4212).

(c) *Listing openings.* (1) The Contractor shall immediately list all employment openings that exist at the time of the execution of this contract and those which occur during the performance of this contract, including those not generated by this contract, and including those occurring at an establishment of the Contractor other than the one where the contract is being performed, but excluding those of independently operated corporate affiliates, at an appropriate local public employment service office of the State wherein the opening occurs. Listing employment

openings with the U.S. Department of Labor's America's Job Bank shall satisfy the requirement to list jobs with the local employment service office.

(2) The Contractor shall make the listing of employment openings with the local employment service office at least concurrently with using any other recruitment source or effort and shall involve the normal obligations of placing a bona fide job order, including accepting referrals of veterans and nonveterans. The listing of employment openings does not require hiring any particular job applicant or hiring from any particular group of job applicants and is not intended to relieve the Contractor from any requirements of Executive orders or regulations concerning nondiscrimination in employment.

(3) Whenever the Contractor becomes contractually bound to the listing terms of this clause, it shall advise the State public employment agency in each State where it has establishments of the name and location of each hiring location in the State. As long as the Contractor is contractually bound to these terms and has so advised the State agency, it need not advise the State agency of subsequent contracts. The Contractor may advise the State agency when it is no longer bound by this contract clause.

(d) *Applicability.* This clause does not apply to the listing of employment openings that occur and are filled outside the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Virgin Islands of the United States, and Wake Island.

(e) *Postings.* (1) The Contractor shall post employment notices in conspicuous places that are

available to employees and applicants for employment.

(2) The employment notices shall--

(i) state the rights of applicants and employees as well as the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified employees and applicants who are special disabled veterans, veterans of the Vietnam era, and other eligible veterans; and

(ii) Be in a form prescribed by the Deputy Assistant Secretary for Federal Contract Compliance Programs, Department of Labor (Deputy Assistant Secretary of Labor), and provided by or through the Contracting Officer.

(3) The Contractor shall ensure that applicants or employees who are special disabled veterans are informed of the contents of the notice (i.e., the Contractor may have the notice read to a visually disabled veteran, or may lower the posted notice so that it can be read by a person in a wheelchair).

(4) The Contractor shall notify each labor union or representative of workers with which it has a collective bargaining agreement, or other contract understanding, that the Contractor is bound by the terms of the Act and is committed to take affirmative action to employ, and advance in employment, qualified special disabled veterans, veterans of the Vietnam era, and other eligible veterans.

(f) *Noncompliance.* If the Contractor does not comply with the requirements of this clause, the Government may take appropriate actions under the rules, regulations, and relevant orders of the Secretary of Labor issued pursuant to the Act.

(g) *Subcontracts.* The *Contractor* shall insert the terms of this clause in all subcontracts or purchase orders of $25,000 or more unless exempted by rules, regulations, or orders of the Secretary of Labor. The Contractor shall act as specified by the Deputy Assistant Secretary of Labor to enforce the terms, including action for noncompliance.

SECTION 5.23
AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES (MN 1990 (FAR 52.222-36)

(a) General. (1) Regarding any position for which the employee or applicant for employment is qualified, the Contractor shall not discriminate against any employee or applicant because of physical or mental disability. The Contractor agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified individuals with disabilities without discrimination based upon their physical or mental disabilities in all employment practices such as--

(i) Recruitment. Advertising, and job application procedures;

(ii) Hiring upgrading, promotion, award of tenure, demotion, transfer, layoff, termination, right of return from layoff, and rehiring;

(iii) Rates of pay or any other form of compensation and changes in compensation;

(iv) Job assignments, job classifications, organizational structures, position descriptions, lines of progression, and seniority lists;

(v) Leaves of absence, sick leave, or any other leave;

(vi) Fringe benefits available by virtue of employment, whether or not administered by the Contractor;

(vii) Selection and financial support for training, including apprenticeships, professional meetings, conferences, and other related activities, and selection for leaves of absence to pursue training;

(viii) Activities sponsored by the Contractor, including social or recreational programs; and

(ix) Any other term, condition, or privilege of employment.

(2) The Contractor agrees to comply with the rules, regulations, and relevant orders of the Secretary of Labor (Secretary) issued under the Rehabilitation Act of 1973 (29 U.S.C. 793) (the Act), as amended.

(b) *Postings.* (1) The Contractor agrees to post employment notices stating (i) the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified individuals with disabilities; and (ii) the rights of applicants and employees.

(2) These notices shall be posted in conspicuous places that are available to employees and applicants for employment. The Contractor shall ensure that applicants and employees with disabilities are informed of the contents of the notice (e.g., the Contractor may have the notice read to a visually disabled individual, or may lower the posted notice so that it might be read by a person in a wheelchair). The notices shall be in a form prescribed by the Deputy Assistant Secretary for Federal Contract Compliance of the U.S. Department of Labor (Deputy As-

sistant Secretary), and shall be provided by or through the Contracting Officer.

(3) The Contractor shall notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the Contractor is bound by the terms of Section 503 of the Act and is committed to take affirmative action to employ, and advance in employment, qualified individuals with physical or mental disabilities.

(c) *Noncompliance.* If the Contractor does not comply with the requirements of this clause, appropriate actions may be taken under the rules, regulations, and relevant orders of the Secretary issued pursuant to the Act.

(d) *Subcontracts.* The Contractor shall include the terms of this clause in every subcontract or purchase order in excess of $10,000 unless exempted by rules, regulations, or orders of the Secretary. The Contractor shall act as specified by the Deputy Assistant Secretary to enforce the terms, including action for noncompliance.

SECTION 5.24
[RESERVED]

SECTION 5.25
DRUG-FREE WORKPLACE (MAY 2001) (FAR 52.223-6)

(a) Definitions. As used in this clause,

"Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in regulation at 21 CPR 1308.11-1308.15.

"Conviction" means a finding of guilt (including a plea of no lo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

"Drug-free workplace" means the site(s) for the performance of work done by the Contractor in connection with a specific contract where employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

"Employee" means an employee of a Contractor directly engaged in the performance of work under a Government contract. Directly engaged is defined to include all direct cost employees and any other Contractor employee who has other than a minimal impact or involvement in contract performance.

"Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

(b) The Contractor, if other than an individual, shall - within 30 days after award (unless a longer period is agreed to in writing for contracts of 30 days or more performance duration); or as soon as possible for contracts of less than 30 days performance duration-

(1) Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the contractor's workplace and speci-

fying the actions that will be taken against employees for violations of such prohibition;

(2) Establish an ongoing drug-free awareness program to inform such employees about-

(i) The dangers of drug abuse in the workplace;

(ii) The contractor's policy of maintaining a drug-free workplace;

(iii) Any available drug counseling, rehabilitation, and employee assistance programs; and

(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

(3) Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph (b)(1) of this clause;

(4) Notify such employees in writing in the statement required by subparagraph (b)(1) of this clause that, as a condition of continued employment on this contract, the employee will-

(i) Abide by the terms of the statement; and

(ii) Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 days after such conviction.

(5) Notify the Contracting Officer in writing within 10 days after receiving notice under subdivision (b)(4)(ii) of this clause, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee;

(6) Within 30 days after receiving notice under subdivision (b)(4)(ii) of this clause of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

(i) Taking appropriate personnel action against such employee, up to and including termination; or

(ii) Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(7) Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs (b)(l) through (b)(6) of this clause.

(c) The Contractor, if an individual, agrees by award of the contract or acceptance of a purchase order, not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

(d) In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (b) or (c) of this clause may, pursuant to FAR 23.506, render the Contractor subject to suspension of contract payments, termination of the contract for default, and suspension or debarment.

SECTION 5.26
FEDERAL, STATE, AND LOCAL TAXES (STATE AND LOCAL ADJUSTMENTS) (APR 2003) (FAR 52.229-3)

(a) As used in this clause-

"After-imposed tax" means any new or increased Federal, State, or local tax or duty, or tax that was excluded on the contract date but whose exclusion was later revoked or amount of exemption reduced during the contract period, other than an excepted tax, on the transactions or property covered by this contract that the Contractor is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax" means any amount of Federal, State, or local tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions or property covered by this contract, but which the Contractor is not required to pay or bear, or for which the Contractor obtains a refund or drawback, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"All applicable Federal, State, and local taxes and duties" means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions or property covered by this contract.

"Contract date" means the effective date of this contract and, for any modification to this contract, the effective date of the modification.

"Excepted tax" means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales, property taxes assessed on completed supplies covered by this contract, or any tax

assessed on the Contractor's possession of, interest in, or use of property, title to which is in the Government.

"Local taxes" includes taxes imposed by a possession or territory of the United States, Puerto Rico, or the Northern Mariana Islands, if the contract is performed wholly or partly in any of those areas.

(b) Unless otherwise provided in this contract, the contract price includes all applicable Federal, State, and local taxes and duties.

(c) The contract price shall be increased by the amount of any after-imposed tax, or of any tax or duty specifically excluded from the contract price by a term or condition of this contract that the Contractor is required to pay or bear, including any interest or penalty, if the Contractor states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(d) The contract price shall be decreased by the amount of any after-relieved tax. The Government shall be entitled to interest received by the Contractor incident to a refund of taxes to the extent that such interest was earned after the Contractor was paid by the Government for such taxes, The Government shall be entitled to repayment of any penalty refunded to the Contractor to the extent that the penalty was paid by the Government.

(e) The contract price shall be decreased by the amount of any Federal, State, or local tax, other than an excepted tax, that was included in the contract price and that the Contractor is required to pay or

bear, or does not obtain a refund of, through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(f) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(g) The Contractor shall promptly notify the Contracting Officer of all matters relating to Federal, State, and local taxes and duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Contractor at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

(h) The Government shall furnish evidence appropriate to establish exemption from any Federal, State, or local tax when-

(1) The Contractor requests such exemption and states in writing that it applies to a tax excluded from the contract price; and

(2) A reasonable basis exists to sustain the exemption.

SECTION 5.27
[RESERVED]

SECTION 5.28
RESERVED

SECTION 5.29
TAXES - FOREIGN NEGOTIATED BENEFITS CON-TRACTS (JAN 1998) (FEHMAR 1652.229-70)

(a) To the extent that this contract provides for performing services outside the United States, its possessions, and Puerto Rico, this clause applies in lieu of any Federal, State, and local taxes clause of the contract.

(b) "Contract date," as used in this clause, means the effective date of this contract or modification.

"Country concerned," as used in this clause, means any country, other than the United States, its possessions, and Puerto Rico, in which expenditures under this contract are made.

"Tax" and "taxes," as used in this clause, include fees and charges for doing business that are levied by the government of the country concerned or by its political subdivisions.

"All applicable taxes and duties," as used in this clause, means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions covered by this contract, pursuant to written ruling or regulation in effect on the contract date, "After-imposed tax," as used in this clause, means any new or increased tax or duty, or tax that was exempted or excluded on the contract date but whose exemption was later revoked or reduced during the contract period, other than excepted tax, on the transactions covered by this contract that the Carrier is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax," as used in this clause, means any amount of tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions covered by this contract, but which the Carrier is not required to pay or bear, or for which the Carrier obtains a refund, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"Excepted tax," as used in this clause, means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales covered by this contract, or any tax assessed on the Carrier's possession of, interest in, or use of property, title to which is in the U.S. Government.

(c) Unless otherwise provided in this contract, the contract price includes all applicable taxes and duties, except taxes and duties that the Government of the United States and the government of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(d) The contract price shall be increased by the amount of any after-imposed tax or of any tax or duty specifically excluded from the contract price by a provision of this contract that the Carrier is required to pay or bear, including any interest or penalty, if the Carrier states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Of-

ficer or to comply with the provisions of paragraph (i) below.

(e) The contract price shall be decreased by the amount of any after-relieved tax, including any interest or penalty. The Government of the United States shall be entitled to interest received by the Carrier incident to a refund of taxes to the extent that such interest was earned after the Carrier was paid by the Government of the United States for such taxes. The Government of the United States shall be entitled to repayment of any penalty refunded to the Carrier to the extent that the penalty was paid by the Government.

(f) The contract price shall be decreased by the amount of any tax or duty, other than an excepted tax, that was included in the contract and that the Carrier is required to pay or bear, or does not obtain a refund of, through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Officer or to comply with the provisions of paragraph (i) below.

(g) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(h) If the Carrier obtains a reduction in tax liability under the United States Internal Revenue Code (Title 26, U.S. Code) because of the payment of any tax or duty that either was included in the contract price or was the basis of an increase in the contract price, the amount of the reduction shall be paid or credited to the Government of the United States as the Contracting Officer directs.

(i) The Carrier shall take all reasonable action to obtain exemption from or refund of any taxes or

duties, including interest or penalty, from which the United States Government, the Carrier, any subcontractor, or the transactions covered by this contract are exempt under the laws of the country concerned or its political subdivisions or which the governments of the United States and of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(j) The Carrier shall promptly notify the Contracting Officer of all matters relating to taxes or duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Carrier at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

SECTION 5.30
COST ACCOUNTING STANDARDS (APR 1998)
(FAR 52.230-2)

(a) Unless the contract is exempt under 48 CFR 9903.201-1 and 9903.201-2, the provisions of 48 CFR Part 9903 are incorporated herein by reference and the Contractor, in connection with this contract, shall -

(1) (CAS-covered Contracts Only) By submission of a Disclosure Statement, disclose in writing the Contractor's cost accounting practices as required by 48 CFR-9903.202-1 through 9903.202-5, including methods of distinguishing direct costs from indirect costs and the basis used for allocating indirect costs, The practices disclosed for this contract shall be the same as the practices currently disclosed and applied

on all other contracts and subcontracts being performed by the Contractor and which contain a Cost Accounting Standards (CAS) clause. If the Contractor has notified the Contracting Officer that the Disclosure Statement contains trade secrets and commercial or financial information which is privileged and confidential, the Disclosure Statement shall be protected and shall not be released outside of the Government.

(2) Follow consistently the Contractor's cost accounting practices in accumulating and reporting contract performance cost data concerning this contract. If any change in cost accounting practices is made for the purposes of any contract or subcontract subject to CAS requirements, the change must be applied prospectively to this contract and the Disclosure Statement must be amended accordingly. If the contract price or cost allowance of this contract is affected by such changes, adjustment shall be made in accordance with subparagraph (a)(4) or (a)(5) of this clause, as appropriate.

(3) Comply with all CAS, including any modifications and interpretations indicated thereto contained in 48 CFR Part 9904, in effect on the date of award of this contract or, if the Contractor has submitted cost or pricing data, on the date of final agreement on price as shown on the Contractor's signed certificate of current cost or pricing data, The Contractor shall also comply with any CAS (or modifications to CAS) which hereafter become applicable to a contract or subcontract of the Contractor. Such compliance shall be required prospectively from the date of applicability to such contract or subcontract.

(4)(i) Agree to an equitable adjustment as provided in the Changes clause of this contract if the

contract cost is affected by a change which, pursuant to subparagraph (a)(3) of this clause, the Contractor is required to make to the Contractor's established cost accounting practices.

(ii) Negotiate with the Contracting Officer to determine the terms and conditions under which a change may be made to a cost accounting practice, other than a change made under other provisions of subparagraph (a)(4) of this clause; provided that no agreement may be made under this provision that will increase costs paid by the United States.

(iii) When the parties agree to a change to a cost accounting practice, other than a change under subdivision (a)(4)(i) of this clause, negotiate an equitable adjustment as provided in the Changes clause of this contract.

(5) Agree to an adjustment of the contract price or cost allowance, as appropriate, if the Contractor or a subcontractor fails to comply with an applicable Cost Accounting Standard, or to follow any cost accounting practice consistently and such failure results in any increased costs paid by the United States. Such adjustment shall provide for recovery of the increased costs to the United States, together with interest thereon computed at the annual rate established under section 6621 of the Internal Revenue Code of 1986 (26 U.S.C. 6621) for such period, from the time the payment by the United States was made to the time the adjustment is effected. In no case shall the Government recover costs greater than the increased cost to the Government, in the aggregate, on the relevant contracts subject to the price adjustment, unless the Contractor made a change in its cost accounting practices of which it was aware or should have been aware at the time of price negotia-

tions and which it failed to disclose to the Government.

(b) If the parties fail to agree whether the Contractor or a subcontractor has complied with an applicable CAS in 48 CFR Part 9904 or a CAS rule or regulation in 48 CPR Part 9903 and as to any cost adjustment demanded by the United States, such failure to agree will constitute a dispute under the Contract Disputes Act (41 U.S.C. 601).

(c) The Contractor shall permit any authorized representatives of the Government to examine and make copies of any documents, papers, or records relating to compliance with the requirements of this clause.

(d) The Contractor shall include in all negotiated subcontracts which the Contractor enters into, the substance of this clause, except paragraph (b), and shall require such inclusion in all other subcontracts, of any tier, including the obligation to comply with all CAS in effect on the subcontractor's award date or if the subcontractor has submitted cost or pricing data, on the date of final agreement on price as shown on the subcontractor's signed Certificate of Current Cost or Pricing Data. If the subcontract is awarded to a business unit which pursuant to 48 CFR 9903.201-2 is subject to other types of CAS coverage, the substance of the applicable clause set forth in subsection 30.201-4 of the Federal Acquisition Regulation shall be inserted. This requirement shall apply only to negotiated subcontracts in excess of $500,000, except that the requirement shall not apply to negotiated subcontracts otherwise exempt from the requirement to include a CAS clause as specified in 48 CFR 9903.201-1.

SECTION 5.31
DISCLOSURE AND CONSISTENCY OF COST ACCOUNTING PRACTICES (APR 1998) (FAR 52.230-3)

(a) The Contractor, in connection with this contract, shall -

(1) Comply with the requirements of 48 CFR 9904.401, Consistency in Estimating, Accumulating, and Reporting Costs, 48 CFR 9904.402, Consistency in Allocating Costs Incurred for the Same Purpose; 48 CFR 9904.405, Accounting for Unallowable Costs; and 48 CFR 9904.406 Cost Accounting Standard--Cost Accounting Period, in effect on the date of award of this contract as indicated in 48 CFR Part 9904.

(2) (CAS-covered Contracts Only) If it is a business unit of a company required to submit a Disclosure Statement, disclose in writing its cost accounting practices as required by 48 CFR 9903.202-1 through 9903.202-5. If the Contractor has notified the Contracting Officer that the Disclosure Statement contains trade secrets and commercial or financial information which is privileged and confidential, the Disclosure Statement shall be protected and shall not be released outside of the Government.

(3)(i) Follow consistently the Contractor's cost accounting practices. A change to such practices may be proposed, however, by either the Government or the Contractor, and the Contractor agrees to negotiate with the Contracting Officer the terms and conditions under which a change may be made. After the terms and conditions under which the change is to be made have been agreed to, the change must be applied prospectively to this contract, and the Disclo-

sure Statement, if affected, must be amended accordingly.

(ii) The Contractor shall, when the parties agree to a change to a cost accounting practice and the Contracting Officer has made the finding required in 48 CFR 9903.201-6(b), that the change is desirable and not detrimental to the interests of the Government, negotiate an equitable adjustment as provided in the Changes clause of this contract with the absence of the required finding, no agreement may be made under this contract clause that will increase costs paid by the United States.

(4) Agree to an adjustment of the contract price or cost allowance, as appropriate, if the Contractor or a subcontractor fails to comply with the applicable CAS or to follow any cost accounting practice, and such failure results in any increased costs paid by the United States. Such adjustment shall provide for recovery of the increased costs to the United States together with interest thereon computed at the annual rate of interest established under the Internal Revenue Code of 1986 (26 U.S.C. 6621), from the time the payment by the United States was made to the time the adjustment is effected.

(b) If the parties fail to agree whether the Contractor has complied with an applicable CAS, rule, or regulation as specified in 48 CFR Parts 9903 and 9904 and as to any cost adjustment demanded by the United States, such failure to agree will constitute a dispute under the Contract Disputes Act (41 U.S.C. 601).

(c) The Contractor shall permit any authorized representatives of the Government to examine and make copies of any documents, papers, and records

relating to compliance with the requirements of this clause.

(d) The Contractor shall include in all negotiated subcontracts, which the Contractor enters into, the substance of this clause, except paragraph (b), and shall require such inclusion in all other subcontracts of any tier, except that -

(1) If the subcontract is awarded to a business unit which pursuant to 48 CFR 9903.201 or 9903.201-2 is subject to other types of CAS coverage, the substance of the applicable clause set forth in subsection 30.201-4 of the Federal Acquisition regulation shall be inserted.

(2) This requirement shall apply only to negotiated subcontracts in excess of $500,000.

(3) The requirement shall not apply to negotiated subcontracts otherwise exempt from the requirement to include a CAS clause as specified in 48 CFR 9903.201-1.

SECTION 5.32
RESERVED

SECTION 5.33
DISCOUNTS FOR PROMPT PAYMENT (FEB 2002)
(FAR 52.232-8)

(a) Discounts for prompt payment will not be considered in the evaluation of offers. However, any offered discount will form a part of the award, and will be taken if payment is made within the discount period indicated in the offer by the offeror. As an alternative to offering a discount for prompt payment in conjunction with the offer, offerors awarded contracts may include discounts for prompt payment on individual invoices.

(b) In connection with any discount offered for prompt payment, time shall be imputed from the date of the invoice. If the Contractor has not placed a date on the invoice, the due date shall be calculated from the date the designated billing office receives a proper invoice, provided the agency annotates such invoice with the date of receipt at the time of receipt. For the purpose of computing the discount earned, payment shall be considered to have been made on the date that appears on the payment check or, for an electronic funds transfer, the specified payment date. When the discount date falls on a Saturday, Sunday, or legal holiday when Federal Government offices are closed and Government business is not expected to be conducted, payment may be made on the following business day.

SECTION 5.34
INTEREST (JUN 1996) (FAR 52.232-17) FEHBAR (JAN 1995)

(a) Except as otherwise provided in this contract under a Price Reduction for Defective Cost or Pricing Data clause or a Cost Accounting Standards clause, all amounts that become payable by the Contractor to the Government under this contract shall bear simple interest from the date due until paid unless paid within 30 days of becoming due. The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 12 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (b) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.

(b) Amounts shall be due at the earliest of the following dates:

(1) The date fixed under this contract.

(2) The date of the first written demand for payment consistent with this contract, including any demand resulting from a default termination.

(3) The date the Government transmits to the Contractor a proposed supplemental agreement to confirm completed negotiations establishing the amount of debt.

(4) If this contract provides for revision of prices, the date of written notice to the Contractor stating the amount of refund payable in connection with a pricing proposal or a negotiated pricing agreement not confirmed by contract modification.

(c) The interest charge made under this clause may be reduced under the procedures prescribed in 32.614-2 of the Federal Acquisition Regulation in effect on the date of this contract.

SECTION 5.35
ASSIGNMENT OF CLAIMS (JAN 1986) (FAR 52.232-23)

(a) The Contractor, under the Assignment of Claims Act, as amended, 31 U.S.C. 3727, 41 U.S.C. 15 (hereafter referred to as "the Act"), may assign its rights to be paid amounts due or to become due as a result of the performance of this contract to a bank, trust company, or other financing institution, including any Federal lending agency. The assignee under such an assignment may thereafter further assign or reassign its right under the original assignment to any type of financing institution described in the preceding sentence.

(b) Any assignment or reassignment authorized under the Act and this clause shall cover all unpaid amounts payable under this contract, and shall not be made to more than one party, except that an assignment or reassignment may be made to one party as agent or trustee for two or more parties participating in the financing of this contract.

(c) The Contractor shall not furnish or disclose to any assignee under this contract any classified document (including this contract) or information related to work under this contract until the Contracting Officer authorizes such action in writing.

SECTION 5.36
DISPUTES (JUL 2002) (FAR 52.233-1)

(a) This contract is subject to the Contract Disputes Act of 1978, as amended (41 U.S.C. 601-613).

(b) Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved under this clause.

(c) "Claim," as used in this clause, means a written demand or written assertion by one of the contracting parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. However, a written demand or written assertion by the Contractor seeking the payment of money exceeding $100,000 is not a claim under the Act until certified. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim under the Act. The submission may be converted to a claim under the Act, by complying with the submission and certification requirements of this

clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time.

(d)(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer for a written decision. A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer.

(2)(i) The Contractor shall provide the certification specified in paragraph (d)(2)(iii) of this clause when submitting any claim exceeding $100,000.

(ii) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(iii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contractor believes the Government is liable; and that I am duly authorized to certify the claim on behalf of the Contractor."

(3) The certification may be executed by any person duly authorized to bind the Contractor with respect to the claim. For Contractor claims of $100,000 or less, the Contracting Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request.

(e) For Contractor-certified claims over $100,000, the Contracting Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(f) The Contracting Officer's decision shall be final unless the Contractor appeals or files a suit as provided in the Act.

(g) If the claim by the Contractor is submitted to the Contracting Officer or a claim by the Government is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Contracting Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(h) The Government shall pay interest on the amount found due and unpaid from (1) the date that the Contracting Officer receives the claim (certified, if required); or (2) the date that payment otherwise would be due, if that date is later, until the date of payment. With regard to claims having defective certifications, as defined in FAR 33.201, interest shall be paid from the date that the Contracting Officer initially receives the claim. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury as provided in the Act, which is applicable to the period during which the Contracting Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(i) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under or relating to the contract, and comply with any decision of the Contracting Officer.

SECTION 5.37
[RESERVED]

SECTION 5.38
CHANGES-- NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.243-70)

(a) The Contracting Officer may at any time, by written order, and without notice to the sureties, if any, make changes within the general scope of this contract in any one or more of the following:

(1) Description of services to be performed.

(2) Time of performance (i.e., hours of the day, days of the week, etc.).

(3) Place of performance of the services.

(b) If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, whether or not changed by the order, the Contracting Officer shall make an equitable adjustment in the contract price, the delivery schedule, or both, and shall modify the contract.

(c) The Carrier must assert its right to an adjustment under this clause within 30 days from the date of receipt of the written order. However, if the Contracting Officer decides that the facts justify it, the Contracting Officer may receive and act upon a proposal submitted before final payment of the contract.

(d) Failure to agree to any adjustment shall be a dispute under the Disputes clause. However, nothing in this clause shall excuse the Carrier from proceeding with the contract as changed.

SECTION 5.39
[RESERVED]

SECTION 5.40
GOVERNMENT PROPERTY (NEGOTIATED BENEFITS CONTRACTS) (JAN 1998) (FEHBAR 1652.245-70)

(a) Government-furnished property. (1) The Government shall deliver to the Carrier, for use in connection with and under the terms of this contract, the Government-furnished property described in this contract together with any related data and information that the Carrier may request and is reasonably required for the intended use of the property (hereinafter referred to as "Government-furnished property").

(2) The delivery or performance dates for this contract are based upon the expectation that Government-furnished property suitable for use (except for property furnished "as-is") will be delivered to the Carrier at the times stated in this contract or, if not so stated, in sufficient time to enable the Carrier to meet the contract's performance dates.

(3) If Government-furnished property is received by the Carrier in a condition not suitable for the intended use, the Carrier shall, upon receipt of it, notify the Contracting Officer, detailing the facts, and, as directed by the Contracting Officer and at Government expense, either repair, modify, return, or otherwise dispose of the property. After completing the directed action and upon written request of the Carrier, the Contracting Officer shall make an equitable adjustment as provided in paragraph (h) of this clause.

(b) Changes in Government-furnished property. (1) The Contracting Officer may, by written notice, (i) decrease the Government-furnished property pro-

vided or to be provided under this contract, or (ii) substitute other Government-furnished property for the property to be provided by the Government, or to be acquired by the Carrier for the Government, under this contract. The Carrier shall promptly take such action as the Contracting Officer may direct regarding the removal, shipment, or disposal of the properly covered by such notice.

(2) Upon the Carrier's written request, the Contracting Officer shall make an equitable adjustment to the contract in accordance with paragraph (h) of this clause, if the Government has agreed in this contract to make the property available for performing this contract and there is any -

(i) Decrease or substitution in this property pursuant to subparagraph (b) (1) above; or

(ii) Withdrawal of authority to use this property, if provided under any other contract or lease.

(c) Title in Government property. (1) The Government shall retain title to all Government-furnished property.

(2) All Government-furnished property and all property acquired by the Carrier, title to which vests in the Government under this paragraph (collectively referred to as "Government property"), are subject to the provisions of this clause. Title to Government property shall not be affected by its incorporation into or attachment to any property not owned by the Government, nor shall Government property become a fixture or lose its identity as personal property by being attached to any real property.

(d) Use of Government property, The Government property shall be used only for performing this

contract, unless otherwise provided in this contract or approved by the Contracting Officer.

(e) Property administration. (1) The Carrier shall be responsible and accountable for all Government property provided under this contract and shall comply with Federal Acquisition Regulation (FAR) subpart 45.5, as in effect on the date of this contract.

(2) The Carrier shall establish and maintain a program for the use, maintenance, repair, protection, and preservation of Government property in accordance with sound industrial practice and the applicable provisions of subpart 45.5 of the FAR.

(3) If damage occurs to Government property, the risk of which has been assumed by the Government under this contract, the Government shall replace the items or the Carrier shall make such repairs as the Government directs. However, if the Carrier cannot effect such repairs within the time required, the Carrier shall dispose of the property as directed by the Contracting Officer. When any property for which the Government is responsible is replaced or repaired, the Contracting Officer shall make an equitable adjustment in accordance with paragraph (h) of this clause.

(4) The Carrier represents that the contract price does not include any amount for repairs or replacement for which the Government is responsible. Repair or replacement of property for which the Carrier is responsible shall be accomplished by the Carrier at its own expense.

(f) Access. The Government and all its designees shall have access at all reasonable times to the premises in which any Government property is locat-

ed for the purpose of inspecting the Government property.

(g) Risk of loss. Unless otherwise provided in this contract, the Carrier assumes the risk of, and shall be responsible for, any loss or destruction of or damage to, Government property upon its delivery to the Carrier. However, the Carrier is not responsible for reasonable wear and tear to Government property or for Government property properly consumed in performing this contract.

(h) Equitable adjustment. When this clause specifies an equitable adjustment, it shall be made to any affected contract provision in accordance with the procedures of the Changes clause. When appropriate, the Contracting Officer may initiate an equitable adjustment in favor of the Government. The right to an equitable adjustment shall be the Carrier's exclusive remedy. The Government shall not be liable to suit for breach of contract for -

(1) Any delay in delivery of Government-furnished property;

(2) Delivery of Government-furnished property in a condition not suitable for its intended use;

(3) A decrease in or substitution of Government-furnished property; or

(4) Failure to repair or replace Government property for which the Government is responsible.

(i) Final accounting and disposition of Government property. Upon completing this contract, or at such earlier dates as may be fixed by the Contracting Officer, the Carrier shall submit, in a form acceptable to the Contracting Officer, inventory schedules covering all items of Government property (including

any resulting scrap) not consumed in performing this contract or delivered to the Government, The Carrier shall prepare for shipment, deliver f.o.b. origin, or dispose of the Government property as may be directed or authorized by the Contracting Officer, The net proceeds of any such disposal shall be credited to the contract price or shall be paid to the Government as the Contracting Officer directs.

(j) Abandonment and restoration of Carrier's premises. Unless otherwise provided herein, the Government-

(1) May abandon any Government property in place, at which time all obligations of the Government regarding such abandoned property shall cease; and,

(2) Has no obligation to restore or rehabilitate the Carrier's premises under any circumstances (e.g., abandonment, disposition upon completion of need, or upon contract completion). However, if the Government-furnished property is withdrawn or is unsuitable for the intended use, or if other Government property is substituted, then the equitable adjustment under paragraph (h) of this clause may properly include restoration or rehabilitation costs.

(k) Communications. All communications under this clause shall be in writing. (1) Overseas contracts. If this contract is to be performed outside of the United States of America, its territories, or possessions, the words "Government" and "Government-furnished" (wherever they appear in this clause) shall be construed as "United States Government" and "United States Government-furnished", respectively.

SECTION 5.41
[RESERVED]

SECTION 5.42
PREFERENCE FOR U.S.-FLAG AIR CARRIERS
(JUN 2003) (FAR 52.247-63)

(a) *Definitions.* As used in this clause-

"International air transportation" means transportation by air between a place in the United States and a place outside the United States or between two places both of which are outside the United States.

"United States" means the 50 States, the District of Columbia, and outlying areas.

"U.S.-flag air carrier" means an air carrier holding a certificate under 49 U.S.C. Chapter 411.

(b) Section 5 of the International Air Transportation Fair Competitive Practices Act of 1974 (49 U.S.C. 40118). (Fly America Act) requires that all Federal agencies and Government contractors and subcontractors use U.S.-flag air carriers for U.S. Government-financed international air transportation of personnel (and their personal effects) or property, to the extent that service by those carriers is available. It requires the Comptroller General of the United States, in the absence of satisfactory proof of the necessity for foreign-flag air transportation, to disallow expenditures from funds, appropriated or otherwise established for the account of the United States, for international air transportation secured aboard a foreign flag air carrier if a U.S.-flag air carrier is available to provide such services.

(c) If available, the Contractor, in performing work under this contract, shall use U.S.-flag carriers

for international air transportation of personnel (and their personal effects) or property.

(d) In the event that the Contractor selects a carrier other than a U.S.-flag air carrier for international air transportation, the Contractor shall include a statement on vouchers involving such transportation essentially as follows:

STATEMENT OF UNAVAILABILITY OF U.S. FLAG AIR CARRIERS

International air transportation of persons (and their personal effects) or property by U.S. flag air carrier was not available or it was necessary to use foreign-flag air carrier service for the following reasons (see section 47.403 of the Federal Acquisition Regulation):

(State reasons): (End of statement)

(e) The Contractor shall include the substance of this clause, including this paragraph (e), in each subcontract or purchase under this contract that may involve international air transportation.

SECTION 5.43
[RESERVED]

SECTION 5.44
AUTHORIZED DEVIATIONS IN CLAUSES (APR 1984) (FAR 52.252-6)

(a) The use in this solicitation or contract of any Federal Acquisition Regulation (48 CFR Chapter 1) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" alter the date of the clause.

(b) The use in this solicitation or contract of any Federal Employees Health Benefits Acquisition Reg-

ulation (48 CFR Chapter 16) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the name of the regulation.

SECTION 5.45
LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (JUN 2003) (FAR 52.203-12)

(a) *Definitions.*

"Agency," as used in this clause, means executive agency as defined in FAR 2.101.

"Covered Federal action," as used in this clause, means any of the following Federal actions:

(1) The awarding of any Federal contract.

(2) The making of any Federal grant.

(3) The making of any Federal loan.

(4) The entering into of any cooperative agreement.

(5) The extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

"Indian tribe" and "tribal organization," as used in this clause, have the meaning provided in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450B) and include Alaskan Natives.

"Influencing or attempting to influence," as used in this clause, means making, with the intent to influence, any communication to or appearance before an officer or employee or any agency, a Member of Congress, an officer or employee of Congress, or an

employee of a Member of Congress in connection with any covered Federal action.

"Local government," as used in this clause, means a unit of government in a State and, if chartered, established, or otherwise recognized by a State for the performance of a governmental duty, including a local public authority, a special district, an intrastate district, a council of governments, a sponsor group representative organization, and any other instrumentality of a local government.

"Officer or employee of an agency," as used in this clause, includes the following individuals who are employed by an agency:

(1) An individual who is appointed to a position in the Government under title 5, United States Code, including a position under a temporary appointment.

(2) A member of the uniformed services, as defined in subsection 101(3), title 37, United States Code.

(3) A special Government employee, as defined in section 202, title 18, United States Code.

(4) An individual who is a member of a Federal advisory committee, as defined by the Federal Advisory Committee Act, title 5, United States Code, appendix 2.

"Person," as used in this clause, means an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit, or not for profit. This term excludes an Indian tribe, tribal organization, or any other Indian organization with respect to expenditures specifically permitted by other Federal law.

"Reasonable compensation," as used in this clause, means, with respect to a regularly employed officer or employee of any person, compensation that is consistent with the normal compensation for such officer or employee for work that is not furnished to, not funded by, or not furnished in cooperation with the Federal Government.

"Reasonable payment," as used in this clause, means, with respect to professional and other technical services, a payment in an amount that is consistent with the amount normally paid for such services in the private sector.

"Recipient," as used in this clause, includes the Contractor and all subcontractors. This term excludes an Indian tribe, tribal organization, or any other Indian organization with respect to expenditures specifically permitted by other Federal law.

"Regularly employed," as used in this clause, means, with respect to an officer or employee of a person requesting or receiving a Federal contract, an officer or employee who is employed by such person for at least 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person for receipt of such contract. An officer or employee who is employed by such person for less than 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person shall be considered to be regularly employed as soon as he or she is employed by such person for 130 working days.

"State," as used in this clause, means a State of the United States, the District of Columbia, or an outlying area of the United States, an agency or in-

strumentality of a State, and multi-State, regional, or interstate entity having governmental duties and powers.

(b) Prohibitions.

(1) Section 1352 of title 31, United States Code, among other things, prohibits a recipient of a Federal contract, grant, loan, or cooperative agreement from using appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract; the making of any Federal grant; the making of any Federal loan; the entering into of any cooperative agreement; or the modification of any Federal contract, grant, loan, or cooperative agreement.

(2) The Act also requires Contractors to furnish a disclosure if any funds other than Federal appropriated funds (including profit or fee received under a covered Federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a Federal contract, grant, loan, or cooperative agreement.

(3) The prohibitions of the Act do not apply under the following conditions:

(i) *Agency and legislative liaison by own employees.*

(A) The prohibition on the use of appropriated funds, in subparagraph (b) (1) of this clause, does not

apply in the case of a payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action if the payment is for agency and legislative liaison activities not directly related to a covered Federal action.

(B) For purposes of subdivision (b)(3)(i)(a) of this clause, providing any information specifically requested by an agency or Congress is permitted at any time.

(C) The following agency and legislative liaison activities are permitted at any time where they are not related to a specific solicitation for any covered Federal action:

(1) Discussing with an agency the qualities and characteristics (including individual demonstrations) of the person's products or services, conditions or terms of sale, and service capabilities.

(2) Technical discussions and other activities regarding the application or adaptation of the person's products or services for an agency's use.

(D) The following agency and legislative liaison activities are permitted where they are prior to formal solicitation of any covered Federal action--

(1) Providing any information not specifically requested but necessary for an agency to make an informed decision about initiation of a covered Federal action;

(2) Technical discussions regarding the preparation of an unsolicited proposal prior to its official submission; and

(3) Capability presentations by persons seeking awards from an agency pursuant to the provisions of

the Small Business Act, as amended by Pub. L. 95-507, and subsequent amendments.

(E) Only those services expressly authorized by subdivision (b)(3)(i)(a) of this clause are permitted under this clause.

(ii) *Professional and technical services.*

(A) The prohibition on the use of appropriated funds, in subparagraph (b)(1) of this clause, does not apply in the case of--

(1) A payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action, if payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law, as a condition for receiving that Federal action.

(2) Any reasonable payment to a person, other than an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action if the payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action. Persons other than officers or employees of a person requesting or receiving a covered Federal action include consultants and trade associations.

(B) For purposes of subdivision (b)(3)(ii)(a) of this clause, "professional and technical services" shall be

limited to advice and analysis directly applying any professional or technical discipline. For example, drafting of a legal document accompanying a bid or proposal by a lawyer is allowable. Similarly, technical advice provided by an engineer on the performance or operational capability of a piece of equipment rendered directly in the negotiation of a contract is allowable. However, communications with the intent to influence made by a professional (such as a licensed lawyer) or a technical person (such as a licensed accountant) are not allowable under this section unless they provide advice and analysis directly applying their professional or technical expertise and unless the advice or analysis is rendered directly and solely in the preparation, submission or negotiation of a covered Federal action. Thus, for example, communications with the intent to influence made by a lawyer that do not provide legal advice or analysis directly and solely related to the legal aspects of his or her client's proposal, but generally advocate one proposal over another are not allowable under this section because the lawyer is not providing professional legal services. Similarly, communications with the intent to influence made by an engineer providing an engineering analysis prior to the preparation or submission of a bid or proposal are not allowable under this section since the engineer is providing technical services but not directly in the preparation, submission or negotiation of a covered Federal action.

(C) Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation and any other requirements in the actual award documents.

(D) Only those services expressly authorized by subdivisions (b)(3)(ii)(A)(1) and (2) of this clause are permitted under this clause.

(E) The reporting requirements of FAR 3.803(a) shall not apply with respect to payments of reasonable compensation made to regularly employed officers or employees of a person.

(c) *Disclosure.*

(1) The Contractor who requests or receives from an agency a Federal contract shall file with that agency a disclosure form, OMB standard form LLL, Disclosure of Lobbying Activities, if such person has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered Federal action), which would be prohibited under subparagraph (b)(1) of this clause, if paid for with appropriated funds.

(2) The Contractor shall file a disclosure form at the end of each calendar quarter in which there occurs any event that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under subparagraph (c)(1) of this clause. An event that materially affects the accuracy of the information reported includes--

(i) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered Federal action; or

(ii) A change in the person(s) or individual(s) influencing or attempting to influence a covered Federal action; or

(iii) A change in the officer(s), employee(s), or Member(s) contacted to influence or attempt to influence a covered Federal action,

(3) The Contractor shall require the submittal of a certification, and if required, a disclosure form by any person who requests or receives any subcontract exceeding $100,000 under the Federal contract.

(4) All subcontractor disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the prime Contractor. The prime Contractor shall submit all disclosures to the Contracting Officer at the end of the calendar quarter in which the disclosure form is submitted by the subcontractor. Each subcontractor certification shall be retained in the subcontract file of the awarding Contractor.

(d) *Agreement.* The Contractor agrees not to make any payment prohibited by this clause.

(e) *Penalties.*

(1) Any person who makes an expenditure prohibited under paragraph (a) of this clause or who fails to file or amend the disclosure form to be filed or amended by paragraph (b) of this clause shall be subject to civil penalties as provided for by 31 U.S.C. 1352. An imposition of a civil penalty does not prevent the Government from seeking any other remedy that may be applicable.

(2) Contractors may rely without liability on the representation made by their subcontractors in the certification and disclosure form.

(3) *Cost allowability.* Nothing in this clause makes allowable or reasonable any costs which would otherwise be unallowable or unreasonable.

Conversely, costs made specifically unallowable by the requirements in this clause will not be made allowable under any other provision.

SECTION 5.46
[RESERVED]

SECTION 5.47
PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (JAN 2005) (FAR 52.209-6)

(a) The Government suspends or debars Contractors to protect the Government's interests. The Contractor shall not enter into any subcontract in excess of $25,000 with a Contractor that is debarred, suspended, or proposed for debarment unless there is a compelling reason to do so.

(b) The Contractor shall require each proposed first-tier subcontractor, whose subcontract will exceed $25,000, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(c) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the Excluded Parties List System). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being in the Excluded Parties List System.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its inclusion in the Excluded Parties List System.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

SECTION 5.48
BANKRUPTCY (JUL 1995) (FAR 52.242-13)

In the event the Contractor enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Contractor agrees to furnish, by certified mail or electronic, commerce method authorized by the contract, written notification of the bankruptcy to the Contracting Office responsible for administering the contract. This notification shall be furnished within five days of the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, and a listing of Government contract numbers and contracting offices for all Government contracts against which final payment has not been made. This obligation remains in effect until final payment under this contract.

SECTION 5.49
FEHBP TERMINATION FOR CONVENIENCE OF THE GOVERNMENT—NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-71)

(a) The Government may terminate performance of work under this contract in whole or, from time to time, in part if the Contracting Officer determines that a termination is in the Government's interest. The Contracting Officer shall terminate by delivering to the Carrier a Notice of Termination specifying the extent of terminating and the effective date.

(b) After receipt of a Notice of Termination, and except as directed by the Contracting Officer, the Carrier shall immediately proceed with the following obligations, regardless of any delay in determining or adjusting any amounts due under this clause:

(1) Stop work as specified in the notice.

(2) Place no further subcontracts except as necessary to complete the continued portion of the contract.

(3) Terminate all subcontracts to the extent they relate to the work terminated.

(4) Assign to the Government, as directed by the Contracting Officer, all right, title, and interest of the Carrier under the subcontracts terminated, in which case the Government shall have the right to settle or to pay any termination settlement proposal arising out of those terminations.

(5) With approval or ratification to the extent required by the Contracting Officer, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts;

the approval or ratification will be final for purposes of this clause.

(6) As directed by the Contracting Officer, deliver to the Government any data, reports, or studies that, if the contract had been completed, would be required to be furnished to the Government.

(7) Complete performance of the work not terminated.

(c) After termination, the Carrier shall submit a final termination settlement proposal to the Contracting Officer in the form and with the certification proscribed by the Contracting Officer. The Carrier shall submit the proposal promptly, but no later than 1 year from the effective date of termination, unless extended in writing by the Contracting Officer upon written request of the Carrier within this 1-year period. However, if the Contracting Officer determines that the facts justify it, a termination settlement proposal may be received and acted on after 1 year or any extension. If the Carrier fails to submit the proposal within the time allowed, the Contracting Officer may determine, on the basis of information available, the amount, if any, due the Carrier because of the termination and shall pay the amount determined.

(d) Subject to paragraph (c) of this clause, the Carrier and the Contracting Officer may agree upon the whole or any part of the amount to be paid or remaining to be paid because of the termination. The amount may include a reasonable allowance for profit on work done. However, the agreed amount, whether under this paragraph (d) or paragraph (e) of this clause, exclusive of costs shown in subparagraph (e)(3) of this clause, may not exceed the total contract

price as reduced by (1) the amount of payments previously made and (2) the contract price of work not terminated. The contract shall be modified, and the Carrier paid the agreed amount. Paragraph (e) of this clause shall not limit, restrict, or affect the amount that may be agreed upon to be paid under this paragraph.

(e) If the Carrier and the Contracting Officer fail to agree on the whole amount to be paid because of the termination of work, the Contracting Officer shall pay the Carrier the amounts determined by the Contracting Officer as follows, but without duplication of any amounts agreed on under paragraph (d) above:

(1) The contract price for completed services accepted by the Government not previously paid for.

(2) The total of –

(i) The costs incurred in the performance of the work terminated, including initial costs and preparatory expense allocable thereto, but excluding any costs attributable to services paid or to be paid under paragraph (e)(1) of this clause;

(ii) The cost of settling and paying termination settlement proposals under terminated subcontracts that are properly chargeable to the terminated portion of the contract if not included in subdivision (e)(2)(i) of this clause; and

(iii) A sum, as profit on subdivision (e)(2)(i) of this clause, determined by the Contracting Officer under 49.202 of the Federal Acquisition Regulation, in effect on the date of this contract, to be fair and reasonable.

(3) The reasonable costs of settlement of the work terminated, including--

(i) Accounting, legal, clerical, and other expenses reasonably necessary for the preparation of termination settlement proposals and supporting data;

(ii) The termination and settlement of subcontracts (excluding the amounts of such settlements); and

(f) The cost principles and procedures of part 31 of the Federal Acquisition Regulation, in effect on the date of this contract, shall govern all costs claimed, agreed to, or determined under this clause.

(g) The Carrier shall have the right of appeal, under the Disputes clause, from any determination made by the Contracting Officer under paragraph (c), (e), or (i) of this clause, except that if the Carder failed to submit the termination settlement proposal or request for equitable adjustment within the time provided in paragraph (c) or (i), respectively, and failed to request a time extension, there is no right of appeal.

(h) In arriving at the amount due the Carrier under this clause, there shall be deducted--

(1) All unliquidated advance or other payments to the Carrier under the terminated portion of this contract;

(2) Any claim which the Government has against the Carrier under this contract; and

(i) If the termination is partial, the Carrier may file a proposal with the Contracting Officer for an equitable adjustment of the price(s) of the continued portion of the contract. The Contracting Officer shall make any equitable adjustment agreed upon. Any

proposal by the Carrier for an equitable adjustment under this clause shall be requested within 90 days from the effective date of termination unless extended in writing by the Contracting Officer.

(j)(1) The Government may, under the terms and conditions it prescribes, make partial payments and payments against costs incurred by the Carrier for the terminated portion of the contract, if the Contracting Officer believes the total of these payments will not exceed the amount to which the Carrier will be entitled.

(2) If the total payments exceed the amount finally determined to be due, the Carrier shall repay the excess to the Government upon demand, together with interest computed at the rate established by the Secretary of the Treasury under 50 U.S.C. App. 1215(b)(2), Interest shall be computed for the period from the date the excess payment is received by the Carrier to the date the excess is repaid.

(k) Unless otherwise provided in this contract or by statute, the Carrier shall maintain all records and documents relating to the terminated portion of this contract for 3 years after final settlement. This includes all books and other evidence bearing on the Carrier's costs and expenses under this contract. The Carrier shall make these records and documents available to the Government, at the Carrier's office, at all reasonable times, without any direct charge. If approved by the Contracting Officer, photographs, microphotographs, or other authentic reproductions may be maintained instead of original records and documents.

SECTION 5.50
FEHBP TERMINATION FOR DEFAULT--NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-72)

(a)(1) The Government may, subject to paragraphs (c) and (d) below, by written notice of default to the Carrier, terminate this contract in whole or in part if the Carrier fails to –

(i) Perform the services within the time specified in this contract or any extension;

(ii) Make progress, so as to endanger performance of this contract (but see subparagraph (a)(2) below); or

(iii) Perform any of the other provisions of this contract (but see subparagraph (a)(2) below).

(2) The Government's right to terminate this contract under subdivisions (1)(ii) and (1)(iii) above, maybe exercised if the Carrier does not cure such failure within 10 days (or more if authorized in writing by the Contracting Officer) after receipt of the notice from the Contracting Officer specifying the failure.

(b) If the Government terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Contracting Officer considers appropriate, supplies or service similar to those terminated, and the Carrier will be liable to the Government for any excess costs for those supplies or services. However, the Carrier shall continue the work not terminated.

(c) Except for defaults of subcontractors at any tier, the Carrier shall not be liable for any excess costs if the failure to perform the contract arises

from causes beyond the control and without the fault or negligence of the Carrier. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the Government in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions, (7) strikes, (8) freight embargoes, and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the Carrier.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Carrier and subcontractor, and without the fault or negligence of either, the Carrier shall not be liable for any excess costs for failure to perform, unless the subcontracted supplies or services were obtainable from other sources in sufficient time for the Carrier to meet the required delivery schedule.

(e) If this contract is terminated for default, the Government may require the Carrier to transfer title and deliver to the Government, as directed by the Contracting Officer, any completed or partially completed information and contract rights that the Carrier has specifically produced or acquired for the terminated portion of this contract.

(f) If, after termination, it is determined that the Carrier was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Government.

(g) The rights and remedies of the Government in this clause are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.51 thru 5.52
[RESERVED]

SECTION 5.53
NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997) (FAR 52.222-1)

If the Contractor has knowledge that any actual or potential labor dispute is delaying or threatens to delay the timely performance of this contract, the Contractor shall immediately give notice, including all relevant information, to the Contracting Officer.

SECTION 5.54
[RESERVED]

SECTION 5.55
EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (DEC 2001) (FAR 52.222-37)

(a) Unless the Contractor is a State or local government agency, the Contractor shall report at least annually, as required by the Secretary of Labor, on--

(1) The number of special disabled veterans, the number of veterans of the Vietnam era, and other eligible veterans in the workforce of the contractor by job category and hiring location; and

(2) The total number of new employees hired during the period covered by the report, and of the total, the number of special disabled veterans, the number of veterans of the Vietnam era, and the number of other eligible veterans; and

(3) The maximum number and the minimum number of employees of the Contractor during the period covered by the report.

(b) The Contractor shall report the above items by completing the Form VETS-100, entitled "Federal Contractor Veterans' Employment Report (VETS-100 Report)."

(c) The Contractor shall submit VETS-100 Reports no later than September 30 of each year beginning September 30, 1988.

(d) The employment activity report required by paragraph (a)(2) of this clause shall reflect total hires during the most recent 12-month period as of the ending date selected for the employment profile report required by paragraph (a)(1) of this clause. Contractors may select an ending date--

(1) As of the end of any pay period between July 1 and August 31 of the year the report is due; or

(2) As of December 31, if the Contractor has prior written approval from the Equal Employment Opportunity Commission to do so for purposes of submitting the Employer Information Report EEO-1 (Standard Form 100).

(e) The Contractor shall base the count of veterans reported according to paragraph (a) of this clause on voluntary disclosure. Each Contractor subject to the reporting requirements at 38 U.S.C. 4212 shall invite all special disabled veterans, veterans of the Vietnam era, and other eligible veterans who wish to benefit under the affirmative action program at 38 U.S.C. 4212 to identify themselves to the Contractor. The invitation shall state that—

(1) The information is voluntarily provided;

(2) The information will be kept confidential;

(3) Disclosure or refusal to provide the information will not subject the applicant or employee to any adverse treatment; and

(4) The information will be used only in accordance with the regulations promulgated under 38 U.S.C. 4212.

(f) The Contractor shall insert the terms of this clause in all subcontracts or purchase orders of $25,000 or more unless exempted by rules, regulations, or orders of the Secretary of Labor.

SECTION 5.56
AUTHORIZATION AND CONSENT (JUL 1995)
(FAR 52.227-1)

(a) The Government authorizes and consents to all use and manufacture, in performing this contract or any subcontract at any tier, of any invention described in and covered by a United States patent (1) embodied in the structure or composition of any article the delivery of which is accepted by the Government under this contract or (2) used in machinery, tools, or methods whose use necessarily results from compliance by the Contractor or a subcontractor with (i) specifications or written provisions forming a part of this contract or (ii) specific written instructions given by the Contracting Officer directing the manner of performance. The entire liability to the Government for infringement of a patent of the United States shall be determined solely by the provisions of the indemnity clause, if any, included in this contract or any subcontract hereunder (including any lower-tier subcontract), and the Government assumes liability for all other infringement to the extent of the authorization and consent hereinabove granted.

(b) The Contractor agrees to include, and require inclusion of, this clause, suitably modified to identify the parties, in all subcontracts at any tier for supplies or services (including construction, architect-engineer services, and materials, supplies, models, samples, and design or testing services expected to exceed the simplified acquisition threshold); however, omission of this clause from any subcontract, including those at or below the simplified acquisition threshold, does not affect this authorization and consent.

SECTION 5.57
NOTICE AND ASSISTANCE REGARDING
PATENT AND COPYRIGHT INFRINGEMENT
(AUG 1996) (FAR, 52.227-2)

(a) The Contractor shall report to the Contracting Officer, promptly and in reasonable written detail, each notice or claim of patent or copyright infringement based on the performance of this contract of which the contractor has knowledge.

(b) In the event of any claim or suit against the Government on account of any alleged patent or copyright infringement arising out of the performance of this contract or out of the use of any supplies furnished or work or services performed under this contract, the Contractor shall furnish to the Government, when requested by the Contracting Officer, all evidence and information in possession of the Contractor pertaining to such suit or claim. Such evidence and information shall be furnished at the expense of the Government except where the Contractor has agreed to indemnify the Government.

(c) The Contractor agrees to include, and require inclusion of, this clause, in all subcontracts at any

tier for supplies or services (including construction and architect-engineer subcontracts and those for materials, supplies, models, samples, or design or testing services) expected to exceed the simplified acquisition threshold at FAR 2.101.

SECTION 5.58
PAYMENT BY ELECTRONIC FUNDS TRANSFER—CENTRAL CONTRACTOR REGISTRATION (OCT 2003) (FAR 52.232-33)

(a) *Method of payment.* (1) All payments by the Government under this contract shall be made by electronic funds transfer (EFT), except as provided in paragraph (a)(2) of this clause. As used in this Clause, the term "EFT" refers to the funds transfer and may also include the payment information transfer.

(2) In the event the Government is unable to release one or more payments by EFT, the Contractor agrees to either--

(i) Accept payment by check or some other mutually agreeable method of payment; or (ii) Request the Government to extend the payment due date until such time as the Government can make payment by EFT (but see paragraph (d) of this clause).

(b) *Contractor's EFT information.* The Government shall make payment to the Contractor using the EFT information contained in the Central Contractor Registration (CCR) database. In the event that the EFT information changes, the Contractor shall be responsible for providing the updated information to the CCR database.

(c) *Mechanisms for EFT payment.* The Government may make payment by EFT through either the Automated Clearing House (ACH) network, subject

to the rules of the National Automated Clearing House Association, or the Fed Wire Transfer System. The rules governing Federal payments through the ACH are contained in 31 CFR part 210.

(d) *Suspension of payment.* If the Contractor's EFT information in the CCR database is incorrect, then the Government need not make payment to the Contractor under this contract until correct EFT information is entered into the CCR database; and any invoice or contract financing request shall be deemed not to be a proper invoice for the purpose of prompt payment under this contract. The prompt payment terms of the contract regarding notice of an improper invoice and delays in accrual of interest penalties apply.

(e) *Liability for uncompleted or erroneous transfers.* (1) If an uncompleted or erroneous transfer occurs because the Government used the Contractor's EFT information incorrectly, the Government remains responsible for — (i) Making a correct payment;

(ii) Paying any prompt payment penalty due; and

(iii) Recovering any erroneously directed funds.

(2) If an uncompleted or erroneous transfer occurs because the Contractor's EFT information was incorrect, or was revised within 30 days of Government release of the EFT payment transaction instruction to the Federal Reserve System, and —

(i) If the funds are no longer under the control of the payment office, the Government is deemed to have made payment and the Contractor is responsible for recovery of any erroneously directed funds; or

(ii) If the funds remain under the control of the payment office, the Government shall not make payment, and the provisions of paragraph (d) of this clause shall apply.

(f) *EFT and prompt payment.* A payment shall be deemed to have been made in a timely manner in accordance with the prompt payment terms of this contract if, in the EFT payment transaction instruction released to the Federal Reserve System, the date specified for settlement of the payment is on or before the prompt payment due date, provided the specified payment date is a valid date under the rules of the Federal Reserve System.

(g) *EFT and assignment of claims.* If the Contractor assigns the proceeds of this contract as provided for in the assignment of claims terms of this contract, the Contractor shall require as a condition of any such assignment, that the assignee shall register separately in the CCR database and shall be paid by EFT in accordance with the terms of this clause. Notwithstanding any other requirement of this contract, payment to an ultimate recipient other than the Contractor, or a financial institution properly recognized under an assignment of claims pursuant to subpart 32.8 is not permitted. In all respects, the requirements of this clause shall apply to the assignee as if it were the Contractor. EFT information that shows the ultimate recipient of the transfer to be other than the Contractor, in the absence of a proper assignment of claims acceptable to the Government, is incorrect EFT information within the meaning of paragraph (d) of this clause.

(h) *Liability for change of EFT information by financial agent.* The Government is not liable for er-

rors resulting from changes to EFT information made by the Contractor's financial agent.

(i) *Payment information.* The payment or disbursing office shall forward to the Contractor available payment information that is suitable for transmission as of the date of release of the EFT instruction to the Federal Reserve System. The Government may request the Contractor to designate a desired format and method(s) for delivery of payment information from a list of formats and methods the payment office is capable of executing. However, the Government does not guarantee that any particular format or method of delivery is available at any particular payment office and retains the latitude to use the format and delivery method most convenient to the Government, If the Government makes payment by check in accordance with paragraph (a) of this clause, the Government shall mail the payment information to the remittance address contained in the CCR database.

(End of clause)

SECTION 5.59
PROHIBITION OF SEGREGATED FACILITIES
(FEB 1999) (FAR 52.222,21)

(a) "Segregated facilities," as used in this clause, means any waiting rooms, work areas, test rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees, that are segregated by explicit directive or are in fact segregated on the basis of race, color, religion, sex, or national origin because of written or oral policies or

employee custom. The term does not include separate or single-user rest rooms or necessary dressing or sleeping areas provided to assure privacy between the sexes.

(b) The Contractor agrees that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not and will not permit its employees to perform their services at any location under its control where segregated facilities are maintained. The Contractor agrees that a breach of this clause is a violation of the Equal Opportunity clause in this contract.

(c) The Contractor shall include this clause in every subcontract and purchase order that is subject to the Equal Opportunity clause of this contract.

SECTION 5.60
[RESERVED]

SECTION 5.61
NOTIFICATION OF EMPLOYEE RIGHTS CONCERNING PAYMENT OF UNION DUES OR FEES (DEC 2004) (FAR 52.222-39)

(a) Definition. As used in this clause—

"United States" means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b) Except as provided in paragraph (e) of this clause, during the term of this contract, the Contractor shall post a notice, in the form of a poster, informing employees of their rights concerning union membership and payment of union dues and fees, in conspicuous places in and about all its plants and of-

fices, including all places where notices to employees are customarily posted. The notice shall include the following information (except that the information pertaining to National Labor Relations Board shall not be included in notices posted in the plants or offices of carriers subject to the Railway Labor Act, as amended (45 U.S.C. 151-188)).

Notice to Employees

Under Federal law, employees cannot be required to join a union or maintain membership in a union in order to retain their jobs. Under certain conditions, the law permits a union and an employer to enter into a union security agreement requiring employees to pay uniform periodic dues and initiation fees. However, employees who are not union members can object to the use of their payments for certain purposes and can only be required to pay their share of union costs relating to collective bargaining, contract administration, and grievance adjustment.

If you do not want to pay that portion of dues or fees used to support activities not related to collective bargaining, contract administration, or grievance adjustment, you are entitled to an appropriate reduction in your payment. If you believe that you have been required to pay dues or fees used in part to support activities not related to collective bargaining, contract administration, or grievance adjustment, you may be entitled to a refund and to an appropriate reduction in future payments.

For further information concerning your rights, you may wish to contact the National Labor Relations Board (NLRB) either at one of its Regional offices or at the following address or toll free number:

National Labor Relations Board
Division of Information
1099 14th Street, N.W.
Washington, DC 20570
1-866-667-6572
1-866316-6572 (TTY)

To locate the nearest NLRB office, see NLRB's website at http://www.nlrb.gov.

(c) The Contractor shall comply with all provisions of Executive Order 13201 of February 17, 2001, and related implementing regulations at 29 CFR Part 470, and orders of the Secretary of Labor.

(d) In the event that the Contractor does not comply with any of the requirements set forth in paragraphs (b), (c), or (g), the Secretary may direct that this contract be cancelled, terminated, or suspended in whole or in part, and declare the Contractor ineligible for further Government contracts in accordance with procedures at 29 CFR Part 470, Subpart B—Compliance Evaluations, Complaint Investigations and Enforcement Procedures. Such other sanctions or remedies may be imposed as are provided by 29 CFR Part 470, which implements Executive Order 13201, or as are otherwise provided by law.

(e) The requirement to post the employee notice in paragraph (b) does not apply to—

(1) Contractors and subcontractors that employ fewer than 15 persons;

(2) Contractor establishments or construction work sites where no union has been formally recognized by the Contractor or certified as the exclusive bargaining representative of the Contractor's employees;

(3) Contractor establishments or construction work sites located in a jurisdiction named in the definition of the United States in which the law of that jurisdiction forbids enforcement of union-security agreements;

(4) Contractor facilities where upon the written request of the Contractor, the Department of Labor Deputy Assistant Secretary for Labor-Management Programs has waived the posting requirements with respect to any of the Contractor's facilities if the Deputy Assistant Secretary finds that the Contractor has demonstrated that—

(i) The facility is in all respects separate and distinct from activities of the Contractor related to the performance of a contract; and

(ii) Such a waiver will not interfere with or impede the effectuation of the Executive order; or

(5) Work outside the United States that does not involve the recruitment or employment of workers within the United States.

(f) The Department of Labor publishes the official employee notice in two variations; one for contractors covered by the Railway Labor Act and a second for all other contractors. The Contractor shall—

(1) Obtain the required employee notice poster from the Division of Interpretations and Standards, Office of Labor-Management Standards, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-5605, Washington, DC 20210, or from any field office of the Department's Office of Labor-Management Standards or Office of Federal Contract Compliance Programs;

(2) Download a copy of the poster from the Office of Labor-Management Standards website at http://www.olms.dol.gov; or

(3) Reproduce and use exact duplicate copies of the Department of Labor's official poster.

(g) The Contractor shall include the substance of this clause in every subcontract or purchase order that exceeds the simplified acquisition threshold, entered into in, connection with this contract, unless exempted by the Department of Labor Deputy Assistant Secretary for Labor-Management Programs on account of special circumstances in the national interest under authority of 29 CFR. 470.3(c). For indefinite quantity subcontracts, the Contractor shall include the substance of this clause if the value of orders in any calendar year of the subcontract is expected to exceed the simplified acquisition threshold. Pursuant to 29 CFR Part 470, Subpart B–Compliance Evaluations, Complaint Investigations and Enforcement Procedures, the Secretary of Labor may direct the Contractor to take such action in the enforcement of these regulations, including the imposition of sanctions for noncompliance with respect to any such subcontract or purchase order. If the Contractor becomes involved in litigation with a subcontractor or vendor, or is threatened with such involvement, as a result of such direction, the Contractor may request the United States, through the Secretary of Labor, to enter into such litigation to protect the interests of the United States.

SECTION 5.62
APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004) (FAR 52.233-4)

United States law will apply to resolve any claim of breach of this contract.

APPENDIX A

ATTACH

2006 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Community-Rated

Health Maintenance Organization Carrier

GROUP HEALTH PLAN, INC.

CONTRACT NO. CS 1930

Effective January 1, 2006

Biweekly net-to-carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

High Option Self Only	$221.65
High Option Self and Family	$478.75
High Deductible Health Plan Self Only	$176.96
High Deductible Health Plan Self and Family	$379.43

APPENDIX C
FEHB Supplemental Literature Guidelines
(RV JAN 2000)

This is the primary guide a Carrier should use to assess whether the Carrier's supplemental marketing literature, including website material, complies with FEHBAR 1603.70, Misleading, Deceptive or Unfair Advertising. (Use the NAIC Advertisements of Accident and Sickness insurance Model Regulation for additional guidance when needed.)

a) GENERAL

1. Section 1.13 of the FMB contract requires that the Carrier may not distribute or display marketing materials or other supplemental literature (including provider directories) in a Federal facility or arrange for the distribution of such documents by Federal agencies unless the documents have been prepared in accordance with FEHBAR 1652.203-70, and the Carrier has certified to OPM that is the case.

2. Review supplemental marketing material for compliance each year, whether or not it changed from the past year.

3. Word the literature simply and concisely to get a readily understandable, attractive marketing piece.

4. Include sufficient detail to ensure accuracy.

5. Under the FUMY, the FBHB brochure is based on text approved by OPM and is a complete statement of benefits, limitations, and exclusions. Include the following statement (website material should include the statement as a preface) in all supplemental literature which in any way discusses Plan benefits:

"This is a summary for brief description] of the features of the [insert Plan's name]. Before making a final decision, please read the Plan's Federal brochure ((insert brochure number]). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure."

6. You may include non-FEHB benefits, i.e., benefits which are not FEHB benefits and are not guaranteed under the Federal contract with the following disclaimer:

"These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all enrollees and family members who become members of [insert Plan's name]."

7. Supplemental literature must be clearly distinguishable from the Federal brochure.

8. Do not use the FEHB logo in your supplemental literature.

9. Do not use material which conflicts with the Federal brochure. If your material conflicts, you must change the material or not distribute it.

b) RATE PRESENTATIONS

Under the FEHBP there are only two categories of enrollment, Self Only and Self and Family. For most enrollments, the premium for each enrollee's enrollment is shared between the enrollee-and the Government, The Government contribution is based on the formula provided in the FEHB law. Deductions for most enrollees' share, along with the Government's contribution, are made in accordance with the schedule on which the employee or annuitant's (retiree) salary or annuitant check is issued by the enrollee's agency or retiree's retirement system.

Most employees are paid biweekly. Annuitants are issued monthly checks.

Employees and annuitants do not have separate categories of enrollment. They pay the same rates, whether on a biweekly, semimonthly, or monthly basis, and receive the same benefits when they are in the same FEHB Plan, except that active Postal employees pay a lesser share, as their cost sharing formula with the Postal Service calls for a greater Government contribution.

The enrollee's share for each FEND Plan for each type of enrollment (Self Only, Self and 'Family) is listed in the FEHB Guide. This Guide is prepared each Open Season and is distributed directly to agencies by OPM; they in turn distribute the Guide to employees, Biweekly and monthly rates are also shown on an insert you prepare for your brochure, Separate guides are prepared for special groups of enrollees, including those for which the Government makes no premium contribution, such as former spouses and employees and dependents with temporarily continued coverage.

In making your rate presentations:

1. List your FEHB rates in each piece of supplemental material which lists benefits. Do not list the rates of any competitor Plan.

2. Immediately above the rates include the following statement:

"These rates .do not apply to all enrollees. If you are in a special enrollment category, please refer to your special FEHB Guide or contact the agency which maintains your health benefits enrollment."

3. If you wish to list Postal rates in addition to non-Postal rates, Postal and non-Postal rates should be clearly identified and listed separately. (Please note there are no monthly Postal rates; upon retirement, Postal employees receive the non-postal contribution.)

c) BENEFIT PRESENTATIONS

Please note the following:

1. Do not compare your benefits or operations with that of any other Plan.

2. Accurately describe your FEHB benefits offering.

3. Avoid incomplete or overstated benefit descriptions, or those which conflict with the Federal brochure.

4. Show applicable coverage limitations, such as day or dollar limitations, coinsurance or deductibles.

5. Do not list exclusions and limitations not listed in the Federal brochure.

6. Do not include general references not in the brochure.

7. Do not reference coverage for which a Federal employee or retiree would have to drop FEUD coverage. Exception: 5 CFR 890.301 provides that an annuitant or former spouse, as defined in 5 U.S.C. S901(10), who cancels FEHBP enrollment for the purpose of enrolling in a Health Maintenance Organization health Plan under sections 1833 or 1876 of the Social Security Act may register to re-enroll. Therefore, if yours is such a Health Maintenance Organization health Plan contracting with Medicare

you must describe your Medicare supplemental program for Medicare-covered retirees.

d) ENROLLMENT INSTRUCTIONS

Enrollment under the FEHBP is governed solely by the Federal Employees Health Benefits law and applicable regulations. The various Federal agencies have responsibility for administering the law and regulations during the annual open enrollment period (Open Season) and at all other times during the year. Agency personnel offices perform the basic health benefits functions, such as instructing employees about the conduct of the Open Season and other health benefits matters, answering employee questions, and processing elections and changes of enrollment, including determinations of eligibility end assignment of effective dates of coverage. Agency payroll offices make the necessary salary deductions.

The Federal instrument for electing to enroll in a Plan or changing an existing enrollment in a Plan from Self Only to Self and Family (or the reverse) is the Standard Form (SF) 2809, or alternative electronic or telephonic method approved by OPM. Carriers must be able to accept electronic -file transfers. The effective date for Open Season enrollments is the first day of the first pay period which begins on or after January 1 for employees; the effective date generally is January 1 for annuitants. The specific effective date for an individual will be assigned by the individual's personnel office.

Covered dependents are as defined in the FEHB regulations. Basically, dependents are immediate family members, including spouse and unmarried children under age 22, When Self and Family cover-

age is established for an individual, all dependents as defined under the regulations are automatically covered as of the effective date assigned by the personnel office, whether or not they are listed on the SF 2809, on other documents, or communicated by electronic or telephonic transmittal. Family members (e.g., newborns) who are added under an existing Self and Family enrollment are automatically covered from the date the individual becomes a family member, e.g., from birth. Personnel offices do not issue any notification when a new dependent is added under an existing Self and Family enrollment and the enrollee does not submit a new SF 2809 or other election instrument,

The agencies are the primary contact point for employees on health benefits enrollment matters. OPM's Office of Retirement Programs performs this function for annuitants (retirees). As highlighted below, Carriers may not impose their own enrollment requirements and procedures.

1. Do not give specific instructions on enrollment.

2. While the Carrier may ask enrollees for information (see Section f) and may follow-up with enrollees and, when necessary, the employing office, do not require that a member complete plan specific enrollment or application forms. You may ask the enrollee to complete "information" forms.) You may ask the enrollee to keep you advised of family member changes and you may verify the change, but failure to complete a form does not render an eligible dependent ineligible.

3. Personnel offices will not stock your Plan's forms. Do not indicate otherwise.

4. If supplemental literature is directed to potential members rather than just-enrolled members, do not include statements indicating otherwise.

5. Again, the Federal brochure, rather than any other plan document, is the member's complete statement of benefits. Do not indicate otherwise.

e) PROVIDER DIRECTORIES

Carriers must distribute a provider directory along with the Plan's Federal brochure. The directory must conform to the requirements listed below. You must either send a copy of it along with your Federal brochures (except that provider directories are not to be sent along with the brochures you will be sending to OPM's distribution center for annuitants) or otherwise make them readily available to agencies and employees. Please send a provider directory to any Federal annuitant who requests a copy. Agencies and their employees will be advised to expect your provider directory.

Please bear in mind that a Federal employee or annuitant choosing your Plan during the Open Season is doing so with the expectation that the Plan's provider directory is accurate and that providers shown will be available starting January 1.

1. Show the Plan's medical facilities (if a group practice Plan) or individual physicians (if an individual practice Plan) or both (if a mixed model Plan). Show the Plan's hospitals also State-the addresses of the medical facilities and show the general location within the service area for individual doctors and hospitals.

2. In the directory, display prominently the following statement: "It is important to know when you enroll in this Plan, services are provided through The

Plan's -delivery system, as described in the Plan's Federal brochure, but the continued participation of any one doctor, hospital or other provider cannot be guaranteed."

3. Do not list enrollment or eligibility requirements on the provider directory,

4. If the geographic area from which the Carrier will accept enrollments is listed on the provider directory, show it exactly as stated in the Plan's Federal brochure. Likewise, show only the service area which has been approved by OPM. Do not list providers (or areas) located outside the service area (or additional geographic area) shown in the Plan's Federal brochure.

f) INFORMATION FORMS

You may distribute forms to obtain information from enrollees about the enrollee and any dependents, For instance, to obtain the information regarding Medicare you will need for rate-setting purposes under the Federal Program, you may ask who is enrolled under Medicare Part A, Medicare Part B or Medicare Parts A and B. For another example, Health Maintenance Organization carriers may ask that a primary care doctor be selected. If you wish to distribute an information form, you may find such forms are more readily returned if they are postage-paid. The form should follow the requirements listed below:

(l) If the member must select a medical group or IPA, also provide space for the member to make such a selection.

(2) Do not indicate enrollment in the Plan is contingent upon completing and returning the form.

APPENDIX D

RULES FOR COORDINATION OF BENEFITS

Model Regulation Service--January 1996
National Association of insurance Commissioners

When a person is covered by two (2) or more plans, the roles for determining the order of benefit payments are as follows:

A. The primary plan must pay or provide its benefits as if the secondary, plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A. plan may consider the benefits paid or provided by another plan only when ii is secondary to that other plan.

D. Order of Benefit Determination. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retir-

ee, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan.

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) The parents are married;

(ii) The parents are not separated (whether or not they ever have been married); or

(iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's

spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(d) If the parents are not married or are separated (whether or not they over were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the noncustodial patent; and then

(iv) The plan of the spouse of the noncustodial parent.

(3) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off not retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection D(1).

Drafting Note: This rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies.

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Drafting Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (COBRA 89) allows the COBRA coverage to continue if the new group plan contains any preexisting condition limitation. In this instance two group plans will cover an individual, and the rule above will be used to determine which of them assumes the primary position. In addition, some states have continuation provisions comparable to the federal law.

(5) Longer or Shorter Length of Coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours slier the first ended.

(b) The start of a new plan does not include:

(1) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of, the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

FIRST AMENDED CLASS ACTION PETITION FOR DAMAGES
(Mo. Cir. Ct. Oct. 31, 2011)

Plaintiff, Jodie Nevils, on behalf of himself and all others similarly situated, alleges and avers the following for this class action against Defendants:

INTRODUCTION AND BACKGROUND

1. This action is brought by the Plaintiff on behalf of himself and others similarly situated regarding the Defendants practice of asserting liens and/or rights of reimbursement against the personal injury settlements of Plaintiff and the Class Members when the Defendants had no legal right to assert said liens.

2. Upon information and belief, Defendant ACS Recovery Services, Inc. ("Defendant ACS") is a private corporate entity that contracts with health insurance companies to assert liens and rights of recovery on their behalf.

3. Defendant Group Health Plan, Inc. ("Defendant Group Health Plan") is a private corporate entity that contracts to provide health insurance to individual persons.

4. Upon information and belief, Group Health Plan contracts with the Federal government, through the Office of Personnel Management as a "carrier" to administer healthcare benefits in accordance with the provisions of the Federal Employee Health Benefits Act (FEHBA). 5 U.S.C. § 8901 *et. seq*.

5. FEHBA is a comprehensive statutory and regulatory scheme that provides federal employees, federal retirees, and their eligible family members with subsidized healthcare benefits.

6. The Defendants routinely engage in a widespread pattern and practice of unlawfully asserting reimbursement rights on healthcare benefits that are paid pursuant to health plans subject to the provisions of FEHBA.

7. For instance, occasionally an individual is injured in an auto accident and that individual's health care benefits are covered through a FEHBA plan. If that individual pursues legal action against the tortfeasor for his/her injuries, the Defendants unlawfully assert a lien for repayment of the health care benefits paid for such treatment.

8. Absent a Federal provision that affords lien/subrogation rights to Defendants, such rights, if they exist, are wholly derivative of state law.

9. There is no Federal provision that provides lien and/or subrogation rights to reimbursement for benefits paid by a FEHBA "carrier" such as Defendant Group Health Plan nor is there any authority for the Defendants to assert liens and/or rights of reimbursement.

10. Under Missouri law, subrogation on personal injury claims prohibited. Accordingly, since Missouri law controls whatever reimbursement rights to which the Defendants would be entitled, Defendants have no right of reimbursement for benefits paid pursuant to a FEBHA health plan.

11. Despite the fact that any reimbursement/subrogation rights are controlled by Missouri state law that prohibits such subrogation, Defendants routinely assert liens on personal injury recoveries of Missouri citizens and subrogate for repayment of health benefits paid out on personal injury claims of Missouri citizens.

12. Defendants pursue such course of conduct despite being informed repeatedly that they are not entitled to reimbursement of such funds under Missouri law.

13. By employing such a policy and business model, Defendants have unlawfully violated the rights of Plaintiff and the Class members as described more particularly below.

14. Further, such conduct of the Defendants, and their agents, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiff and the Class members such that punitive damages are appropriate and warranted.

JURISDICTION AND VENUE

15. This Court has personal jurisdiction over Defendant Group Health Plain and Defendant ACS since the Defendants transacted business in Missouri, violated the law within the State of Missouri, and otherwise has sufficient minimum contacts with the state of Missouri as more particularly described below. Defendants have sufficient minimum contacts, and in fact, substantial contacts with Missouri such that the maintenance of this suit does not offend traditional notions of fair play and substantial justice. Defendants have voluntarily submitted itself to the jurisdiction of this Court and jurisdiction is proper because, among other things:

a. Defendants committed tortious acts within this state;

b. Plaintiffs' and the Class members' causes of action directly arise from the commission of tortious and unlawful acts in Missouri by Defendants;

c. Plaintiffs' and the Class members' causes of action directly arise from Defendants' transaction(s) of business in Missouri;

d. Defendants should reasonably anticipate being haled into court in Missouri to answer for its unlawful acts. Missouri has a strong interest in providing a forum for its residents aggrieved by violations of the law.

16. Venue is proper in this Circuit pursuant to RSMo § 508.010 in that a substantial part of the events giving rise to the claim occurred in within this Circuit.

PARTIES

Plaintiff

17. Plaintiff Jodie Nevils currently resides in Saint Louis County, Missouri.

Defendants

18. Defendant Group Health Plan is a private health insurance provider. Group Health Plan is organized under the laws of Missouri and is authorized to do business in the Sate of Missouri.

19. Defendant ACS Recovery Services, Inc. is a Delaware Corporation.

ALLEGATIONS COMMON TO ALL COUNTS

20. On or about November 2, 2006, representative Plaintiff Jodie Nevils was injured in a motor vehicle accident.

21. Plaintiff Nevils received treatment for his injuries sustained in the accident from numerous healthcare providers.

22. Plaintiff Nevils asserted a personal injury claim against the driver tortfeasor for his injuries sustained in the November 2, 2006 accident.

23. Plaintiff Nevils reached a settlement with the tortfeasor, paid through the tortfeasor's auto insurance policy, in compensation for his injuries, medical treatment, and pain and suffering, sustained in the accident.

24. Plaintiff Nevils was entitled to medical insurance coverage through a federal health benefit plan. The health plan that covers Plaintiff is governed by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 ("FEHBA").

25. The federal government has contracted with Defendant Group Health Plan to act as a "carrier" under FEHBA to provide health benefits and administer the subsidized healthcare plan provided under FEHBA to enrollees such as Ms. Nevils.

26. Plaintiff Nevils' medical bills related to the auto accident were paid by Defendant Group Health Plan.

27. Defendant Group Health Plan and Defendant ACS unlawfully asserted a lien in the amount of $6,592.24 for healthcare benefits and services provided to Mr. Nevils in treatment of his accident related injuries.

28. The United States Supreme Court held in *Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677 (2006) that FEHBA's preemption clause – 5 U.S.C. § 8902(m)(1) – does not apply to subrogation or reimbursement rights of an insurer. Therefore, Missouri state law applies to the reimbursement rights of an insurer.

29. Missouri law has long prohibited subrogation in personal injury claims and does not allow for reimbursement to health insurers for payments made for treatment received related to a personal injury. This prohibition on subrogation of personal injury claims exists even if there is a contractual provision in the health benefit plan that purports to allow for such subrogation rights.

30. There is no Federal provision that provides a reimbursement/subrogation right to such medical benefits paid pursuant to a FEHBA plan. Accordingly, such reimbursement rights are controlled by Missouri law, which expressly prohibits subrogation of health care benefits paid in connection with personal injury settlements.

31. Upon information and belief, despite being aware and informed of their lack of entitlement to reimbursement, the Defendants continued to pursue payment of unlawful reimbursement from Plaintiff's personal injury settlement.

32. On or about, January 29, 2010, Mr. Nevils remitted $6,592.24 to Defendant GHP by and through its agent, Defendant ACS Recovery.

33. Subsequently, Defendants converted the funds from Mr. Nevils' personal injury settlement.

CLASS ACTION ALLEGATIONS

34. This action is brought as a plaintiff class pursuant to Missouri Rule of Civil Procedure 5.08. Plaintiff brings this action on her own behalf and all others similarly situated, as representative of the following class.

> All Missouri residents who received health insurance coverage through a FEHBA plan

who have had a right of reimbursement asserted against a personal injury claim or settlement by Defendants and such reimbursement was paid to Defendants within five years of the filing date of this Petition.

35. The particular members of the class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of the Defendants. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

36. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class members. The only material difference between the Class members' claims is the exact monetary amount to which each member of the Class is entitled. The principal common issues include, but are certainly not limited to the following:

(a) Whether Defendants entered into express and/or implied agreements with the federal government providing for reimbursement/subrogation rights on personal injury claims;

(b) Whether a provision for reimbursement/subrogation rights on personal injury

claims contained in such a statement of benefits would be unenforceable under Missouri law;

(c) Whether Defendants employ a policy and business model of unlawfully asserting reimbursement/subrogation rights to which they are not entitled;

(d) Whether Defendants unlawfully asserted reimbursement/subrogation rights against personal injury claims/settlements in violation of Missouri law;

(e) Whether the Defendants utilized aggressive collection practices to collect reimbursement of funds from the Plaintiff and the Class to which they were not entitled under applicable law;

(f) Whether such uniform practices asserted against all class members were unlawful and, thereby, unjustly profited the Defendants at the Plaintiff's and the Class members' expense;

(g) Whether Defendants have been unjustly enriched at the Plaintiff's and the Class members' expense through the misconduct described herein;

(i) Whether Defendants violated the Missouri Merchandising Practices Act through the above described misconduct;

(k) Whether Defendants should be enjoined from continuing their unfair, predatory, and abusive conduct;

37. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories.

38. Plaintiff will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel in complex class actions. Counsel is committed to the vigorous prosecution of this action.

39. Certification of a plaintiff class is appropriate in that Plaintiff and the Class members seek monetary damages, common questions predominate over any individual questions, and a plaintiff class action is superior for the fair and efficient adjudication of this controversy. A plaintiff class action will cause an orderly and expeditious administration of the Class members' claims and economies of time, effort and expense will be fostered and uniformity of decisions will be ensured. Moreover, the individual class members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against the likes of the Defendants.

40. Alternatively, certification of a plaintiff class is appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for the Defendants or adjudications with respect to individual members of the Class as a practical matter would be dispositive of the interests of the other members not parties to the adjudications or would substantially impair or impede their ability to protect their interests.

41. Defendants have acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corre-

sponding declaratory relief with respect to the class as a whole.

COUNT I
(Violation of the Missouri Merchandising Practices Act)

42. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

43. RSMo. § 407.020 prohibits the use of any "deception, fraud, false pretense, false promise, misrepresentation, unfair practice or the concealment, suppression, or omission of any material fact in connection with the sale or advertisement of any merchandise in trade or commerce. . ."

44. An "unfair practice" is defined by Missouri law, 15 CSR 60-8.020, as any practice which:

(A) Either-

1. Offends any public policy as it has been established by the Constitution, statutes or common law of this state, or by the Federal Trade Commission, or its interpretive decisions; or

2. Is unethical, oppressive or unscrupulous; and

(B) Presents a risk of, or causes, substantial injury to consumers.

45. An "unfair practice" is further defined by Missouri law, 15 CSR 60-8.040, accordingly:

(1) It is an unfair practice for any person in connection with the advertisement or sale of merchandise to violate the duty of good faith in solicitation, negotiation and per-

formance, or in any manner fail to act in good faith.

46. "Merchandise" is defined by the MPA, at RSMo. § 407.010(4), to include the providing of "services" and, therefore, encompasses the providing for the administration of medical care and billing for the same.

47. "Person" is defined by the MPA, at RSMo. § 407.010(5), to include any "for-profit or not-for-profit corporation. . .company. . .business entity or association, and any agent, employee, salesman, partner, officer, director, member, stockholder, associate, trustee or cestui que trust thereof."

48. The above described behavior, misconduct, and unlawful acts of the Defendants violate the Missouri Merchandising Practices Act by, among other things, constituting an unfair practice and breach of the duty of good faith as required under the Act.

49. As a result of the above described wrongful acts, Plaintiff and the Class members have suffered damages.

COUNT II
(Unjust Enrichment)

50. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

51. As alleged above, the Defendants have engaged in a pattern and practice of unlawfully subverting the financial interests of Plaintiff and the Class for their own pecuniary gain.

52. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled to and received in violation of Missouri law.

53. Said benefits were unlawfully obtained to the detriment of Plaintiff and the Class members.

54. Allowing Defendants to retain the aforementioned benefits violates fundamental principles of justice, equity, and good conscience.

COUNT III
(Conversion)

55. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

56. As alleged above, Defendants have engaged in a pattern and practice of unlawfully depriving the Plaintiff and the Class of certain property.

57. Plaintiff and the Class were legally entitled to the property in question when the Defendants deprived Plaintiff of the property.

58. Defendants acted purposefully and wrongfully in dispossessing Plaintiff and the Class of the property in question.

59. Such unfair misconduct by Defendants caused economic injury and other damages to the Plaintiff and the Class.

COUNT IV
(Injunctive Relief)

60. Plaintiff incorporates all preceding paragraphs as though fully set forth herein.

61. As set forth herein, Defendants have improperly taken the property of Plaintiff and the Class Members for its own pecuniary benefit as prohibited by law.

62. Upon information and belief, Defendants continue the unlawful practices enumerated above

causing irreparable harm to the Plaintiff and the Class members.

63. As set forth herein, Plaintiff and the Class have a high probability of success on the merits of this action.

64. Accordingly, Defendants should be enjoined from continuing to perpetuate such predatory and unfair practices on consumers, such as Plaintiff and the Class.

PRAYER FOR DAMAGES AND RELIEF

WHEREFORE, Plaintiff, on behalf of himself and all members of the Class respectively prays for judgment against the Defendants as follows:

a) For an order certifying that this action may be maintained as a class action and appointing Plaintiff and his counsel, to represent the Class;

b) For a declaration that the Defendants' actions violated the Plaintiff's and the Class members' rights under Missouri law as plead herein;

c) For all actual damages, punitive damages, statutory damages, penalties, and remedies available for the Defendants' violations of Plaintiff's and the Class members' rights under Missouri law;

d) For a declaration that Defendants, through the actions and misconduct as alleged above, have been unjustly enriched and an order that Defendants disgorge any unlawfully gained proceeds;

e) For pre-judgment interest as provided by law;

f) For post-judgment interest as provided by law;

g) For a permanent injunction enjoining Defendants from engaging in the unlawful practices as enumerated above;

h) For an award to Plaintiff and the Class their reasonable attorneys' fees;

i) For an award to Plaintiff and the Class of their costs and expenses of this action;

j) For such other and further relief as the Court may deem necessary and proper.

Respectfully submitted,

s/

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No. SC93134
St. Louis County Circuit Court Case No. 11SL-CC00535-01

In the Supreme Court of Missouri

May Session, 2016

Jodie Nevils,

Appellant,

v. APPEAL FROM THE CIRCUIT COURT OF ST. LOUIS COUNTY

Group Health Plan, Inc., and ACS Recovery Services, Inc.,

Respondents.

Now at this day come again the parties aforesaid, by their respective attorneys, and the Court here being now sufficiently advised of and concerning the premises, doth consider and adjudge that the judgment aforesaid, in form aforesaid, by the said Circuit Court of St. Louis County rendered, be reversed, annulled and for naught held and esteemed, and that the said Appellant be restored to all things which he has lost by reason of said judgment. It is further considered and adjudged by the court that the said cause be remanded to the said Circuit Court of St. Louis County for further proceedings to be had therein, in conformity with the opinion of this court herein delivered; and that the said Appellant recover against the said Respondents costs and charges herein expended, and have execution therefor.

(Opinion filed.)

STATE OF MISSOURI-Sct.

I, BILL L. THOMPSON, Clerk of the Supreme Court of Missouri, certify that the foregoing is a full, true and complete transcript of the judgment of said Supreme Court, entered of record at the May Session thereof, 2016 and on the 3rd day of May 2016, in the above entitled cause.

Given under my hand and seal of said Court at the City of Jefferson, this 19th day of May 2016.

s/ _____
Clerk

s/ _____
Deputy Clerk

[*1]

86TH CONGRESS *1st Session*

HOUSE OF REPRESENTATIVES

REPORT No. 957

GOVERNMENT EMPLOYEES HEALTH BENEFITS PROGRAM

AUGUST 20, 1959.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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MR. MURRAY, from the Committee on Post Office and Civil Service, submitted the following

REPORT

[To accompany S. 2162]

The Committee on Post Office and Civil Service, to whom was referred the bill (S. 2162) to provide a health benefits program for Government employees, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

AMENDMENT

The amendment proposed by the committee to S. 2162 strikes out all after the enacting clause and inserts in lieu thereof a substitute text which appears in italic type in S. 2162, as reported by the committee of the House. A discussion of the effect of this proposed amendment is contained in the explanation of the bill, as reported.

STATEMENT

PURPOSE

The general purpose of this legislation is to facilitate and strengthen the administration of the activities of the Government generally and to improve personnel administration in the Government by providing a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive Government-wide program of insurance for Federal employees and their dependents, the costs of which will be shared by the Government, as employer, and its employees.

At the present time, a wide gap exists between the Government, in its capacity of employer, and employers in private enterprise, with [*2] respect to health benefits for employees. Enlightened, progressive private enterprise almost universally has been establishing and operating contributory health benefit programs for its employees. Until now, the Government has made scant progress in this area.

This bill is designed to close the gap which now exists and bring the Government abreast of most private employers. It will enable Government employees to purchase protection, at a cost which is within their means, from the unanticipated and usually oppressive costs of medical care and treatment in the event of sickness or injury, as well as the often crushing expense of so-called catastrophic illness or serious injury. Availability of this health protection program to Government employees will be of material assistance in improving the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian

personnel so urgently needed to assist in maintaining and improving our strong national defense and in the operation of other essential Government programs.

The addition of the health insurance program provided by the bill to the existing fringe benefits package for Government employees—which currently includes retirement and survivor annuities, group life insurance, annual and sick leave, compensation for job-connected injury or death, and other benefits—will fill a long, keenly felt need and will place the Government on a substantially equal level with progressive industry in respect to employee fringe benefits.

Legislation to establish a health benefits program for Federal employees has been before the Post Office and Civil Service Committee in each Congress beginning with the 83d. Hearings were held in 1956 on an administration proposal to provide Federal employees protection against the bankrupting expenses of extended catastrophic illness or injury, with the Government sharing the cost. The reported bill incorporates the outstanding feature of that plan—"major medical" protection against the expense of catastrophic illness or injury—and, in addition, provides protection for basic health needs. Thus the bill affords Federal employees an opportunity to obtain comprehensive insurance for health services at moderate cost.

The urgent need for a joint Government-employee health benefits program is emphasized by the fact that there is widespread and increasing recognition on the part of the public that both basic health and major medical insurance coverages are essential to protect wage-earners and their families.

In 1940, approximately 4 million individuals were enrolled in basic hospital plans; at the beginning of 1959 the number of individuals who had this protection had skyrocketed to 123 million—70 percent of the population. Similar spectacular increases have been recorded in surgical and regular medical programs. In the comparatively new field of major medical insurance, participation in plans offering this protection has virtually exploded from 700,000 in 1952 to 17 million in 1959. It is a source of concern to this committee that no more than a relative handful of Federal employees now have such major medical coverage. This extremely important protection will be made available by the reported bill, along with the more generally prevalent basic coverage which now is held by approximately 70 percent of Federal employees.

[*3] COMMITTEE REVIEW OF PROGRAM

The committee emphasizes that the health benefits program provided by this legislation represents an entirely new area of Federal employees' fringe benefits in which the Government is without previous experience, and that extreme care will be necessary, particularly in the initial stages, to protect both the Government and its employees. The committee intends to conduct a continuing review of the operation of the program in order to carry out its responsibilities under section 136 of the Legislative Reorganization Act of 1946.

SUMMARY OF MAJOR PROVISIONS

The reported bill makes basic and catastrophic health protection available to approximately 2 million Federal employees and their dependents. Employees will have free choice among health benefits

plans in four major categories, including (1) a Government-wide service benefit plan, such as is offered by Blue Cross-Blue Shield, (2) a Government-wide indemnity benefit plan, such as is currently offered by several insurance companies, (3) one of several employee organization plans, such as the present health plans of the National Association of Letter Carriers and the National Federation of Post Office Clerks, and (4) a comprehensive medical plan, which may be either a group-practice prepayment plan (such as the Kaiser Foundation plan in California and the Group Health Association plan in Washington, D.C.) or an individual-practice prepayment plan (such as the Group Health Insurance plan in New York). The Government-wide service benefit plan and the Government-wide indemnity benefit plan each will include at least two levels of benefits.

The reported bill retains the provisions of the Senate-passed bill (1) providing for 50 percent contribution by the Government to subscription charges and (2) establishing biweekly maximum contributions of $1.75 for an individual employee, $4.25 for an employee and family, and $2.50 for a female employee and family including a nondependent husband.

Employees will be eligible for enrollment in health benefits plans without having to pass any physical examination and, in the event of their separation from Government service, may convert their coverage to a private health benefits plan without undergoing any physical examination. It is intended that each of the foregoing plans will provide a wide range of hospital, surgical, medical, and related benefits designed to afford the employees full or sub-

stantially full protection against expenses of both common and catastrophic illness or injury.

Responsibility and authority for administration of the health benefits program in the interest of both the employees and the Government is vested in the U.S. Civil Service Commission. The Commission will execute contracts with the Government-wide service plan carrier and the Government-wide indemnity plan carrier and will make suitable arrangements to place the other types of plans in effect through appropriate contracts or agreements.

Provision is made for the prime insurer under the Government-wide indemnity benefit plan to reinsure with such other qualified companies as may elect to participate, in accordance with an equitable formula. [*4] Similar provision is made for the prime carrier under the Government-wide service benefit plan to allocate its rights and obligations under its contract among such of its affiliates as may elect to participate.

No person will be excluded from participation in the health benefits program because of race, sex, health status, or (at the time of first opportunity to enroll) age.

With respect to the service benefit plan and the indemnity benefit plan, the reported bill requires the Commission to enter into contracts which call for premium rates that are competitive with those generally charged for a new group health insurance sold to large employers. For the premiums agreed upon, the Commission is charged with negotiating the best possible basic health and major medical benefits. These provisions are designed to assure maximum

health benefits for employees at the lowest possible cost to themselves and to the Government.

The Government will contribute 50 percent to the subscription charge for each enrolled employee, but not more than certain amounts which the Commission may prescribe from time to time subject to (1) biweekly minimums of $1.25 for an individual employee or annuitant, $3 for an employee or annuitant and family, and $1.75 for a female employee and family including a nondependent husband, and (2) biweekly maximums of $1.75 for an individual employee, $4.25 for an employee or annuitant and family, and $2.50 for a female employee and family including a nondependent husband. The provisions for contributions are related to the service benefit plan and the indemnity benefit plan authorized by section 4 of the bill, thus permitting each employee to exercise independent judgment and obtain the plan which best suits his or her individual needs or family circumstances.

The bill provides for setting aside portions of total contributions (1) not exceeding 1 percent for administrative expenses, and (2) not exceeding 3 percent to provide a contingency reserve or margin for adjustment based on experience without seeking further legislation.

The Commission will make available to each employee eligible to enroll in a health benefits plan information which will enable the employee to exercise an informed choice among the various plans. Each employee will be issued an appropriate certificate summarizing the benefits under the plan selected.

The bill authorizes the Chairman of the Civil Service Commission to appoint an advisory commit-

tee of five members, comprising employees enrolled under the act and elected officers of employee organizations. This committee (which will perform a solely advisory function) replaces the Advisory Council which would have been provided by the Senate bill.

The bill omits those parts of the Senate bill which would have (1) established a Bureau of Retirement and Insurance in the Civil Service Commission to administer the health benefits program along with the retirement and life insurance programs, and (2) required prior submission of health benefits contracts to the Post Office and Civil Service Committees of the Senate and the House of Representatives. In the judgment of the committee, the assignment of duties in connection with administration of the program should be left to the [*5] discretion of the Civil Service Commission, which is responsible for success of the program. The committee is convinced that the prior submission of contracts would have tended to impede and interfere with progress in the establishment and operation of the program.

COST

On the basis of the formula, provided by section 7 of the reported bill, for a 50 percent Government contribution subject to certain limitations, the cost of the program for the first year of operation is estimated at $214 million, of which approximately one-half will be paid by the Government.

ADMINISTRATIVE REPORTS

The reports of the Director of the Bureau of the Budget and the Chairman of the U.S. Civil Service Commission (directed to S. 2162 as passed by the Senate and submitted before the committee amendment was drafted) recommend approval of a health

benefits program identical in principle to the program which will be established by the bill, as reported by this committee, except that such reports favor a Government contribution of 33½ percent in lieu of 50 percent as authorized by the reported bill. The Post Office Department, the Department of Health, Education, and Welfare, the Department of Defense, and the Comptroller General of the United States also submitted reports favorable to the principles of the reported bill.

The committee points out that the Civil Service Commission, the Bureau of the Budget, major employee organizations, and leading companies and associations which now provide health benefits and will participate in this program, have agreed to the terms of the reported bill, in a spirit of compromise and cooperation, in order that an effective and financially sound Government employees health benefits program may become a reality at the earliest possible time. The committee desires to express its appreciation for this cooperation and joint endeavor to bring about a result in the general interest of the Government and all parties concerned. It is believed that the final agreement represented by the reported bill will receive overwhelming approval by Federal employees, full cooperation by the companies and associations which expect to participate, and support of the Government departments and agencies concerned.

The text of the reports of the Bureau of the Budget, the Civil Service Commission, the Department of Defense, the Department of Health, Education, and Welfare, and the General Accounting Office appear immediately following the explanation of the bill, as reported.

EXPLANATION OF THE BILL, AS REPORTED

SHORT TITLE

The first section of the bill creates a short title which permits the provisions of this legislation to be conveniently cited as the "Federal Employees Health Benefits Act of 1959."

[*6] DEFINITIONS

Section 2 defines the technical terms used throughout the act, as follows:

Subsection (a) defines the term "employee" to include an appointive or elective officer or employee in or under the executive, judicial, or legislative branches of the U.S. Government and an employee of the District of Columbia government. Included within the definition are Members of Congress, the Official Reporters of Debates of the Senate and their employees, and employees of Gallaudet College. The definition of the term "employee" does not include members of the Armed Forces ("uniformed services") and noncitizen employees whose permanent duty stations are located outside the United States. Also excluded are employees of certain corporations which are under the supervision of the Farm Credit Administration, of which corporations any member of the board of directors is elected or appointed by private interests.

This definition will operate to provide coverage under the bill to the same groups of employees who are covered under the Federal Employees' Group Life Insurance Act of 1954, as amended, except that employees of the Tennessee Valley Authority, who have been specifically excluded from the definition, will not be covered. This exclusion was made at the request of the Tennessee Valley Authority because em-

ployees of the Authority have their own contributory health benefits program which has been operating successfully.

Subsection *(b)* defines the term "Government" as meaning the Government of the United States of America to distinguish it from State and local governments.

Subsection *(c)* defines the term "annuitant" to include—

(1) an employee who retires on or after the effective date (July 1, 1960), mentioned in section 15, under the Civil Service Retirement Act or other retirement system for civilian employees, on an immediate annuity after 12 or more years of service or for disability;

(2) a member of a family who receives an immediate annuity as the survivor of a retired employee described in paragraph (1), or an employee who dies after completing 5 or more years of service;

(3) an employee who receives benefits under the Federal Employees' Compensation Act as a result of illness or injury to himself and who because of the illness or injury is determined by the Secretary of Labor to be unable to return to duty; and

(4) a member of a family who receives monthly compensation as the surviving beneficiary of—

(A) an employee who dies of an illness or injury compensable under the Federal Employees' Compensation Act after 5 or more years of service, or

(B) a former employee who dies while receiving compensation benefits and is held by the Secretary of Labor to have been unable to return to duty.

Subsection (*d*) defines the term "member of family" to include—

an employee's or annuitant's spouse;

his unmarried children under age 19, including—

(A) an adopted child, and

(B) a stepchild or recognized natural child who lives with him in a regular parent-child relationship; and [*7]

(C) his unmarried children, regardless of age, who are incapable of self-support because of a disability that existed prior to their reaching the age of 19.

Subsection (*e*) defines the term "dependent husband" to mean a husband who is incapable of self-support by reason of mental or physical disability which can be expected to continue for more than 1 year.

Subsection *(f)* defines the term "health benefits plan" as meaning essentially a group insurance policy, contract, agreement, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.

Subsection (*g*) defines the term "carrier" to include a voluntary association, corporation, partnership, or other nongovernmental organization which provides, pays for, or reimburses the cost of health services under group insurance contracts, agreements, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition includes a health benefits plan duly sponsored or underwritten by an employee organization.

Subsection (*h*) defines the term "Commission" as meaning the U.S. Civil Service Commission, to which is assigned the responsibility of administering this legislation.

Subsection (*i*) defines the term "employee organization" to include an association or other organization of employees which—

(A) is national in scope or

(B) in which membership is open to all employees of a department or agency of the Government who are eligible to enroll in a health benefits plan

and which on or before December 31, 1959, applies to the Commission for approval of a plan which it sponsors or underwrites.

In addition to the health benefits plans provided by national employee labor organizations, this language would include employee organization sponsored plans such as those of the Federal Bureau of Investigation, the National Security Agency, the U.S. citizen employees of the Panama Canal, the Foreign Service, the Central Intelligence Agency, and the Postal Hospital Association of St. Louis.

ELECTION OF COVERAGE

Section 3 provides generally for election of health benefits plans by employees.

Subsection (*a*) permits an eligible employee to enroll, either as an individual or for self and family, in a health benefits plan approved by the Civil Service Commission. This subsection authorizes the Commission (1) to prescribe regulations fixing the time, manner, and conditions of eligibility for enrollment and (2) to exclude employees from enrolling

on the basis of the nature and type of their employment or conditions pertaining thereto such as, but not limited to, short-term appointments, seasonal or intermittent employment, and employment of like nature. However, no employee may be excluded by the Commission's regulations solely on the basis of the hazardous nature of his job.

Subsection (*b*) permits an annuitant to continue his coverage after he retires if he was enrolled in a health benefits plan under the act for a period of not less than (A) the 5 years of service immediately [*8] preceding retirement or (B) the full period or periods of service between the date he first becomes eligible to enroll in a plan and the date on which he becomes an annuitant, whichever is shorter. This subsection also permits the survivor of a deceased employee or annuitant to continue his coverage if the survivor was enrolled as a member of the family at the time of the employee's or annuitant's death.

Where a husband and wife are both Federal employees, subsection (c) permits either one to enroll individually or to enroll for self and family and prohibits any person from enrolling both as an employee or annuitant and as a member of the family.

Subsection (*d*) permits an employee or annuitant to change from individual to family coverage or vice versa at such time and under such conditions as the Commission may prescribe.

Subsection (*e*) permits an employee or annuitant to transfer his enrollment from one health benefits plan to another at such time and under such conditions as the Commission may prescribe.

HEALTH BENEFITS PLANS

Section 4 authorizes the Commission to contract for or approve the following health benefits plans:

(1) One Government-wide service benefit plan of the type commonly provided by Blue Cross-Blue Shield under which payment for medical services is made, insofar as possible, under contracts with hospitals, physicians, and other vendors of medical services. Where such payment is impracticable, it will be made directly to the employee.

(2) One Government-wide indemnity benefit plan such as is commonly provided by commercial insurance companies. Under this type of plan payment for medical services may be made directly to the employee or directly to the vendor of the medical services.

(3) Employee organization plans which are sponsored or underwritten by employee organizations. To be eligible under the bill, the organization which sponsors or underwrites the plan must have had in operation a plan which provided health benefits to its members on July 1, 1959. Employees will be able to enroll in these employee organization plans only if at the time of enrollment they are members of the organization.

(4) Two types of comprehensive medical plans—(A) group-practice prepayment plans and (B) individual-practice prepayment plans.

The Government-wide service benefit plan and the Government-wide indemnity benefit plan will each offer two options providing varying levels of benefits at varying subscription charges so that every employee will have an unrestricted choice between the service type plan and the indemnity type plan

and, within each plan, between benefits and subscription charges which best suit his family circumstances and his ability to pay.

An employee who belongs to an association which sponsors an employee organization plan will have the additional choice of enrolling in his association's plan. Employees who are located in areas in which a group-practice prepayment plan or an individual-practice prepayment plan operates will have the further choice of enrolling in such a comprehensive medical plan.

[*9] TYPES OF BENEFITS

Section 5 stipulates that the benefits to be provided under the plans described in section 4 may be of the following types:

(1) Service benefit plan—
  (A) hospital benefits.
  (B) surgical benefits.
  (C) in-hospital medical benefits.
  (D) ambulatory patient benefits.
  (E) supplemental benefits.
  (F) obstetrical benefits.

(2) Indemnity benefit plan—
  (A) hospital care.
  (B) surgical care and treatment.
  (C) medical care and treatment.
  (D) obstetrical benefits.
  (E) prescribed drugs, medicines, and prosthetic devices.
  (F) other medical supplies and services.

(3) Employee organization plans—

Benefits of the types described in paragraph (1) or (2) or both.

(4) Comprehensive medical plans—

Benefits of the types described in paragraph (1) or (2) or both.

The general effect of section 6 is to authorize and require the Civil Service Commission to take appropriate action to contract, or to make other arrangements, for health-benefits plans.

CONTRACTING AUTHORITY

Subsection (*a*) authorizes the Civil Service Commission to negotiate contracts with qualified carriers offering plans described in section 4. The subsection requires each such contract to be for a uniform term of at least 1 year and permits the contract to be made automatically renewable from term to term in the absence of notice of termination by either party.

Paragraph (1) of subsection (b) requires the prime carrier for the indemnity benefit plan to be a company which is licensed to issue group health insurance in all the States and the District of Columbia.

Under the related authority to prescribe minimum standards for carriers, vested in the Civil Service Commission by subsection (d), it is expected that one of the standards for the prime indemnity carrier will be the volume of group health insurance business it has handled in the past. The Commission is expected to choose as a prime carrier a company that has by the volume of its operations demonstrated the experience and capacity necessary to handle what will undoubtedly be the largest policy of its kind in the world. In addition to requiring licensing in all the States and the District of Columbia, the Commission will presumably apply some volume-of-business test, such as requiring that the carrier selected shall, in the most recent year for which data

are available, have made at least 1 percent of all group health insurance benefit payments in the United States.

[*10] Paragraph (2) of subsection (*b*) requires the prime carrier of the indemnity benefit plan to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance payments in the United States during the latest year for which such information is available. The reinsurance formula is to be determined by the carrier and approved by the Commission. Under paragraph (2) the prime carrier for the service benefit plan is similarly required to allocate its rights and obligations among such of its affiliates as may elect to participate, in accordance with an equitable formula which the carrier and its affiliates will determine and which the Commission will approve.

This practice of reinsuring and allocating rights and obligations follows closely the policy laid down by the Congress in the Federal Employees' Group Life Insurance Act of 1954 and ensures that all qualified companies and organizations which are engaged in providing protection against the cost of health services will share equitably in the contracts to be negotiated under this act, if they desire to do so.

Subsection (*c*) requires that any contract negotiated by the Civil Service Commission shall contain a detailed statement of benefits offered and include such maximums, limitations, exclusions and other definition of benefits as the Commission may deem necessary or desirable.

Subsection (*d*) authorizes the Civil Service Commission to prescribe regulations fixing minimum

standards for participating health benefits plans and for carriers offering such plans.

Subsection (*e*) prohibits the Civil Service Commission from entering into any contract or approving any plan which excludes employees or annuitants, or members of their families, because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

Subsection (*f*) requires each plan approved by the Commission to permit an employee or annuitant whose enrollment in the plan is terminated, other than by his voluntary cancellation of enrollment, to convert from group coverage to individual coverage. It is expected that when the group coverage of an employee or annuitant terminates, he will have continued temporary protection for 31 days without current contributions so that he may have reasonable opportunity to convert to individual coverage and thus avoid an interruption in his protection against the cost of health services. The terms or conditions under which the employee or annuitant may convert will be prescribed by the carrier and approved by the Civil Service Commission and the employee will have to pay the periodic charges of the converted coverage directly to the carrier.

Subsection (*g*) requires that the converted coverage shall, at the option of the employee or annuitant, be noncancellable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

Subsection (*h*) stipulates that the premiums to be charged by the carriers for approved health benefits plans shall reasonably and equitably reflect the cost of the benefits provided. The subsection requires that the premiums for the service benefit plan and

the indemnity benefit plan be determined on a basis which, in the judgment of the Civil Service Commission, is consistent with the lowest schedule of basic rates generally charged for new group health benefits plans [*11] issued to large employers. This subsection further requires that premium rates determined for the first contract term shall be continued for subsequent contract terms except that they may be readjusted for any subsequent term based on past experience and benefit adjustments under the subsequent contract. Any readjustment in rates is required to be made in advance of the contract term in which the new rates will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of carriers which issue group health benefits plans to large employers.

The effect of subsection (*h*) is to make certain that the premiums which the Government will have to pay for the service benefit plan and the indemnity benefit plan will not be more costly than those charged by the industry to other large employers.

CONTRIBUTIONS

Section 7 provides for contributions by the Government and by employees to subscription charges.

Paragraph (1) of subsection (*a*) specifies the Government's contributions to the subscription charge for each enrolled employee and annuitant as the lesser of (A) 50 percent of the subscription charge or (B) such other amounts as the Commission prescribes.

The amounts which the Commission may prescribe, in accordance with clause (B), above, must not (i) be less than $1.25 or more than $1.75 biweekly for an individual who is enrolled for self alone, (ii) be

less than $3 or more than $4.25 biweekly for an individual who is enrolled for self and family, or (iii) be less than $1.75 or more than $2.50 biweekly for a female employee who enrolls for self and family if the family includes a nondependent husband.

Paragraph (2) of subsection (a) authorizes the withholding from an individual's salary or annuity of the difference between the total subscription charge of the plan in which he is enrolled and the Government's contribution to the subscription charge. The employees' contributions will be made through payroll deductions, as is the case with respect to employees' contributions under the Civil Service Retirement Act and the Federal Employees' Group Life Insurance Act of 1954.

Paragraph (3) authorizes the Civil Service Commission to adjust the contributions of the Government and of the employees and annuitants to a particular plan whenever past experience indicates that such an adjustment is warranted or whenever there is a change in benefits offered by the plan. Any such adjustment must preserve the same ratio between the Government's and employee's or annuitant's contribution as existed originally, with the one exception that the Government's contribution cannot be adjusted to a biweekly amount which is more than the $1.75, $4.25, or $2.50 specified in subsection (*a*)(1).

The net effect of this provision is that the Commission will prescribe the maximum contribution which the Government will make to each approved health benefits plan and so be able to control the total cost of the program to the Government.

It is expected that the Government contributions prescribed by the Commission will be 50 percent of

the subscription charge to the approved plans in which most employees are enrolled. Thus the [*12] Government and the employee or annuitant will each contribute 50 percent of the subscription charge.

There may be some plans or options within plans which will provide benefits superior to the benefits under other plans or options and for which the subscription charge per enrollment will exceed the sum of the prescribed maximum Government contribution plus a matching contribution from the employee or annuitant. Where an employee chooses to enroll in such a superior-benefit plan or option, the excess portion of the subscription charge will be withheld from his salary.

Any adjustment in contribution rates must, within the specified limits, preserve the ratio which originally existed between the employee's or annuitant's contribution and the Government's contribution. If in the future an adjustment will (because of the maximums imposed on the Government's contribution) result in destroying this ratio, it is contemplated that the Civil Service Commission will call the matter to the attention of the Congress in advance so that the legislation can be amended to increase the maximum Government contributions if the Congress wishes.

Subsection (*b*) authorizes the Civil Service Commission to continue an employee's coverage for a period of up to 1 year (exclusive of any temporary extension of coverage) while he is in a leave-without-pay status. Because the employee will not be drawing any pay during this period, no contributions can be withheld from his salary and, therefore, the Commission is authorized to waive both the employee's and the Government's contributions while the employee is in a leave-without-pay status.

Subsection (*c*) directs that the Government's contribution toward the cost of the program be paid from the following sources:

(1) For most employees, from the appropriation or fund which is used for the payment of their salaries.

(2) In the case of an elected official, from the appropriation or fund which is available for payment of other salaries of the same office or establishment.

(3) In the case of an employee in the legislative branch whose salary is paid by the Clerk of the House of Representatives, from the contingent fund of the House.

Subsection (*d*) directs the Civil Service Commission to provide for the conversion of the biweekly contribution rates to weekly, monthly or other rates in the case of individuals who are paid on other than a biweekly basis and permits the converted rate to be adjusted to the nearest cent.

EMPLOYEES' HEALTH BENEFITS FUND

Subsection (*a*) of section 8 creates an employees health benefits fund, to be administered by the Civil Service Commission, which is made available without fiscal year limitation for the payment of all premiums to approved health benefits plans and into which all contributions of employees, annuitants and the Government shall be paid.

Subsection (6) requires that portions of the contributions made by employees, annuitants, and the Government shall be regularly set aside in the fund as follows:

(1) A percentage, not to exceed 1 percent of all such contributions, determined by the Commission as reasonably adequate to pay its administrative expenses under this bill. [*13]

(2) For each health benefits plan a percentage, not to exceed 3 percent of the contributions for such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. It is expected that these contingency reserves will be available to defray anticipated increases in future premiums and it is hoped that their use in this manner will postpone for a reasonable period of time the necessity of increases in contribution rates. Authorization is also contained in this subsection for applying the contingency reserves to reduce the contributions of employees and the Government or to increase the benefits provided by the plan from which the reserves are derived. It is required that the contingency reserves set aside for each plan will be used for the purposes mentioned above with respect to that plan only.

Subsection (*c*) authorizes the Secretary of the Treasury to invest any of the moneys in the employees health benefits fund in interest bearing obligations of the United States and to sell such obligations for the purposes of the fund. All interest derived from these investments and the proceeds from the sale of obligations will become a part of the fund.

ADMINISTRATIVE EXPENSES

Subsection (*a*) of section 9 authorizes the expenditure from the employees' life insurance fund for the fiscal years 1960 and 1961, without regard to limitations on that fund, of such sums as may be necessary to pay the administrative expenses of the

Civil Service Commission in carrying out the provisions of the Federal Employees Health Benefits Act of 1959. The subsection requires that reimbursement for sums so expended be made from the employees' health benefits fund to the employees' life insurance fund, together with interest at a rate to be determined by the Secretary of the Treasury.

Subsection (*b*) makes the employees' health benefits fund available (1) to reimburse the employees' life insurance fund, as indicated and (2), within such limitations as may be specified annually by the Congress, to pay the expenses of the Commission in administering this legislation for the fiscal year 1962 and subsequent years.

ADMINISTRATION

Subsection (*a*) of section 10 authorizes the Civil Service Commission to promulgate such regulations as may be necessary to give effect to the intent and purposes of the Federal Employees Health Benefits Act of 1959.

Subsection (*b*) requires the Civil Service Commission to specify in its regulations the beginning and ending dates of coverage of employees and annuitants and members of their families. The subsection permits the Commission, by regulation, to grant a temporary extension of coverage upon cancellation (other than voluntary cancellation) of enrollment. Where the cancellation is for reasons other than the death of the employee or annuitant, it is expected that the temporary extension of coverage will continue for 31 days. Where the cancellation is on account of the death of the employee or annuitant, this subsection permits a temporary extension of coverage for members of the family for as long as 90 days after

the end of the pay period or month in which the death of the employee or annuitant occurred. In any case, it is intended that the temporary extension of coverage will be [*14] without current contributions by the employee or annuitant, or members of his family, and by the Government.

Subsection (*c*) provides that an employee enrolled under this legislation who is removed or suspended without pay and later reinstated or restored to duty because the removal or suspension was unjustified or unwarranted shall have his coverage restored so that he may enjoy the same benefits as if removal or suspension had not occurred.

Subsection (*d*) requires that the Civil Service Commission shall make available to each employee such information as may be necessary to enable him to exercise an informed choice among the various plans available. This information with respect to the Government-wide service benefit plan and the Government-wide indemnity benefit plan must be in a form acceptable to the Commission and will be developed by the Commission after consultation with the carriers. It is expected that information with respect to the employee organization plans and the comprehensive medical plans will be prepared and distributed by the respective carriers; however, this information must also be approved by the Commission. Each employee who enrolls in a health benefits plan will be issued an appropriate certificate summarizing the services or benefits provided by the plan. These certificates will also have to be approved by the Commission.

STUDIES, REPORTS, AND AUDITS

Subsection (*a*) of section 11 stipulates that the Civil Service Commission shall make a continuing study of the operation and administration of this legislation, including surveys and reports on health benefits plans available to employees and on the experience of such plans. It is expected that in making this study the Commission will include any instances of apparent overutilization of hospital facilities and any instances of apparently excessive charges by purveyors of health services.

Subsection (*b*) requires carriers to furnish such reports as the Civil Service Commission determines to be necessary to enable it to carry out its functions under this legislation and permits the Commission and representatives of the General Accounting Office to examine any records of the carriers which either the Commission or the General Accounting Office deem to be pertinent to the purposes of this legislation.

Subsection (*c*) requires Government departments, agencies, and independent establishments to keep such records, make such certifications, and furnish the Civil Service Commission such information and reports as may be necessary to enable the Commission to carry out its functions under the legislation.

REPORTS TO CONGRESS

Section 12 requires the Commission to transmit to the Congress an annual report concerning the operation of the Federal Employees Health Benefits Act of 1959.

ADVISORY COMMITTEE

Section 13 requires the Chairman of the Civil Service Commission to appoint a committee composed of five members, who will serve [*15] without compensation, to advise the Commission regarding matters of concern to employees under this legislation. Each member of the committee will be an employee enrolled under this legislation, or an elected officer of a national employee organization.

JURISDICTION OF COURTS

Section 14 gives the district courts of the United States original jurisdiction, concurrent with the Court of Claims, of any civil action or claim against the United States founded upon this legislation.

EFFECTIVE DATE

Section 15 makes the benefit and contributions provisions of this legislation effective on the first day of the first pay period which begins on or after July 1, 1960, and, by implication, makes the other provisions of the legislation effective upon enactment.

ADMINISTRATIVE REPORTS

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., August 4, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D.C.

MY DEAR MR. CHAIRMAN: Reference is made to your letter of July 8, 1959, requesting the views of the Bureau of the Budget on S. 2162, to provide a

health benefits program for Government employees, presently before your committee.

Since 1954 this administration has advocated, and now continues to advocate, the establishment of a voluntary health insurance program for Federal employees. Specific programs were proposed in 1954, 1955, 1956, and 1957, each proposal being an attempt to formulate a better program. In 1958 the administration gave priority to pay increase legislation and recommended that action on employee health insurance legislation be postponed. It should be noted that during these years Government annual expenditures for Federal employee pay and benefits have been increased by substantial amounts due to increases in pay rates under both the statutory and prevailing wage systems, increases in annuities under employee retirement systems, the liberalization of the premium pay benefits system, the liberalization of the civil service retirement system and the establishment of such new benefits as the allowances for uniforms and the group life insurance and unemployment compensation systems.

Following this administration's basic policy that the Federal employee should be compensated for the services he renders to the Government under a pay and benefit system that is reasonably comparable in structure and level with the compensation provided by progressive private employers, the Bureau of the Budget favors legislation authorizing a Federal employee health insurance program with benefits providing financial protection against the cost of health care reasonably comparable with those benefits provided in private employment. Although the existing Federal employee fringe benefit [*16] system has been reported to be already more liberal

than the typical private business fringe benefit system, it does not include a program of health insurance benefits. Adding these benefits to the existing system will further increase the total value of the Federal employee fringe benefit package. Under these circumstances it is essential that the value added by the new health insurance benefit program be kept in line with private industry health benefits.

The new health insurance benefits should he made available only to employees who earn them by rendering services to the Government under the new program after it becomes effective. Compensation in the form of pay and benefits is paid to employees for services rendered. Former employees who rendered service under a compensation system which did not include these health insurance benefits have already been paid in full for their services in the form of pay and benefits already received or in vested rights to payment of future benefits already earned. Whenever salary or benefits are adjusted an effective date must be selected. It may be unfortunate that some former employees must miss eligibility by narrow margins, and a retroactive approach is often suggested. However, a retroactive approach actually creates an inequity where none would otherwise exist. For while prospective entitlement is firmly linked to services rendered under a compensation agreement, retroactive entitlement is pure gratuity. If any former employee is granted this special gift, then any other former employees who are excluded by the particular retroactive date selected will feel they merit equal consideration. The new health insurance benefits should, therefore, be provided only to employees who render service to the Government after a prospective effective date.

S. 2162, now before your committee, while including several desirable features, falls short of providing an acceptable employee health insurance program in two major respects: the cost to the Government is higher than justifiable in establishing a health insurance benefits program reasonably comparable with existing private business programs, and the organization and administrative system is defective.

The cost-sharing feature of the bill would require the Government to pay one-half of the premiums rather than one-third, as established for the Federal employee group life insurance program in 1954. The first-year cost of the bill to the Government is estimated in the Senate committee report to be $145.3 million, which must be increased by $2.5 million in the first year and $25 million in the fifth year to include the Government share of the cost of annuitant coverage. This amount is substantially higher than the $80 million figure which is actually needed as one-third of the cost, including the cost of annuitant coverage, of a sound program providing a benefit level in line with private industry plans, and providing a sound experience basis for accumulating the facts on which an appropriate Federal employee health benefits program can evolve for the future. It would be prudent for the Government to seek the patterns and level of health benefit protection best suited to the problems of the Federal employee, the benefits that will yield the most effective return for the premium dollar. Experience elsewhere strongly suggests that an effective program will evolve best from a conservative base. Sound development can occur as the genuine needs of the covered employees are clearly defined through experience, and a pattern of effective health care benefits grows up to meet

[*17] these needs. The bill should be modified to clearly provide this sound, conservative beginning.

The organization and administrative provisions of S. 2162 should be modified. The Civil Service Commission will advise you in full detail concerning these modifications. This report will comment only on three organization provisions: the advisory council, the Civil Service Commission reorganization, and the submittal of proposed contracts and regulations.

The functions and membership of the proposed advisory council are not designed to aid sound administration. The council's assigned functions include making investigations of the administration of the program, and receiving reports direct from carriers and employees. Such assignment would confuse the Commission's authority in its relations with carriers, employing agencies, and employees. The Civil Service Commission should be unmistakably responsible for the success of this program. The council's functions should be advisory only. The council's membership should reflect its character as an element of a Federal employee benefit program, and should include appropriate Government officials, ex officio, together with employees, or their representatives, who are contributing and participating in the health insurance system. There is no need to create a statutory organization based on an assumption that the Civil Service Commission may refuse to seek the advice of responsible experts in the health insurance field. Neither is there basis for assuming that the Commission may foster a program which will be deleterious to the public generally, nor that the Commission will fail to give adequate consideration to all parties, including all qualified prospective carriers. The Government's lack of experience in ad-

ministering a health insurance program for its employees and the asserted absence of facts upon which to base decisions does not argue for splitting responsibility in this program between the Civil Service Commission and the advisory council. Rather, it requires placing a special responsibility on the Commission to proceed prudently, to develop factual experience as rapidly as feasible, and to build soundly, and it places a special responsibility on those who contribute to the design of the authorizing statute to provide the clear-cut authority and proper organization that will be so essential. Section 12 should be modified accordingly.

The proposed statutory reorganization of the Civil Service Commission would interfere, to no defined purpose, with the existing statutory power and responsibility of the Chairman of the Civil Service Commission to determine the internal organization of the Commission's business and to designate officers and employees to perform assigned functions. It is especially important in this new program to avoid a rigid organization prescription that could hamper the proper adjustment of administration with experience. Section 13 should be deleted from the bill.

The requirement that the Commission submit proposed contracts and regulations to the Senate and House Committees on Post Office and Civil Service is unnecessary to assure energetic administration by the Commission and is clearly improper if it is intended to provide the committees with a power of prior review of executive action. Subsection (a) of section 16 should be deleted from the bill.

S. 2162, as passed by the Senate, includes several features which are desirable in a program of Federal employee health benefits, but [*18] it seeks to

provide a level of benefits at an unnecessarily high cost, and it provides an unsound system and organization for administration. Unless S. 2162 is modified as to cost and administrative provisions, as above noted, the Bureau of the Budget would not favor enactment of the bill.

Sincerely yours,

MAURICE H. STANS, *Director*.

CIVIL SERVICE COMMISSION,
August 5, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives.

DEAR MR. MURRAY: In response to your letter of July 8, 1959, I am forwarding the Commission's views on the bill S. 2162, to provide a health benefits program for Government employees, as the bill has been amended by the Senate Post Office and Civil Service Committee and reported to the Senate. These views would also apply to H.R. 8210 and H.R. 8211, which are identical to S. 2162.

In the interest of brevity we are not here including a section analysis of S. 2162. The Senate committee's report of July 2, 1959, (No. 468) contains an explanation of the bill by sections. Except as noted hereinafter, the Commission construes the bill as stated in that explanation.

As the central personnel agency of the executive branch, the Commission considers enactment of a health insurance program for Federal employees

highly desirable. Such a program would fill the one remaining major gap in employee fringe benefits and be of inestimable value in attracting and retaining Federal personnel.

We are in complete agreement with the fundamental concepts under lying S. 2162. Very briefly, these would—

(1) Permit employees a free choice among a Government-wide service benefit plan, a Government-wide indemnity benefit plan, a local group practice prepayment plan, and an employee organization plan.

(2) Require contributions from the employee and from the Government.

(3) Make the Commission responsible for the overall administration of the program while sharing the day-to-day operating responsibilities with the employing agencies and the insurance carriers.

(4) Create a central fund into which all receipts would be deposited and out of which all disbursements would be paid.

The soundness of these same concepts (except for the first, which is pertinent only to health insurance) has been solidly established by the efficient operation of the Federal employees' group life insurance program.

The Commission does not, however, altogether favor the manner in which S. 2162 applies these four general principles. We also have serious reservations about several other provisions of the bill. Under the circumstances, we find S. 2162 sufficiently objectionable to compel [*19] us to report unfavorably. If the objectionable features were corrected, we

would find the bill acceptable and a good basis for a successful, enduring health benefits program.

There follows a discussion of what we consider to be the objection-able features of the bill, together with suggestions for rectifying them.

RETROACTIVITY

Regardless of how long before July 1, 1960, S. 2162 were enacted, it would become generally effective no earlier than that date. Section 2(b)(2), however, contains a proviso which would extend the benefits of the bill to certain employees and certain survivors who qualify for annuity between the time the bill is enacted and the time it becomes generally effective.

We appreciate and are not unsympathetic with the purpose of this proviso which is to protect those people who would otherwise be denied the benefits of the bill because, owing to circumstances beyond their control, they are separated before its effective date.

The situation which the proviso in section 2 (b)(2) seeks to cure is not new. It occurs each time beneficial legislation is enacted and on each such occasion it appears that numbers of people have been denied benefits because they were prematurely separated. Depending largely on the value of the benefit, the group which considers itself aggrieved by having been denied the benefits ranges all the way from those who were separated as little as 1 day too early to those who were separated as much as 5 or even 10 years too early.

It is unfortunate that any person has to be denied a benefit because he has been prematurely separated, but we know from long experience that the proviso in section 2(b)(2), although it may slightly

lessen the number of persons who will feel aggrieved, will not appreciably remedy the situation. The proviso in section 2(b)(2) would extend health benefits to certain employees who retire involuntarily or for disability during the interval between the enactment and effective date of the bill and to survivors of certain employees who die during this interval. The number of people whom the proviso will affect will depend on how long this interval may be, but in any event the proviso will not affect the large number of employees who, for example, will voluntarily retire during the interval and later claim they had no knowledge of the fact that, had they waited, they could have qualified. Nor, for another example, will it affect the even larger number of employees who retired (or died) 1 day, 1 week, 1 year before the enactment date.

A line of demarcation must be drawn somewhere. The fairest and firmest place to draw the line is at the date the enacted bill becomes effective. Any retroactivity, unless it were complete, would be discriminatory and would intensify the aggrievement the excluded groups would feel and the representations they would make for having the benefits extended to them. The Commission, therefore, recommends that the following text be deleted from the bill:

(1) Subsection 2(b)(2) on page 23, beginning in line 13 and ending in line 18.

(2) Subsection 3(b)(2) beginning on page 26, line 25, and ending on page 27, line 11.

[*20] BENEFITS AND CONTRIBUTIONS

There are at least two aspects of the bill's benefit-contribution structure which, in the Commission's

view, are so objectionable as to make S. 2162 unsatisfactory. These aspects are as follows:

(1) Government contributions:

At the maximum rates specified in section 7(a), the total contribution required of the Government has been estimated by the Senate committee at $145.3 million annually. We would make two observations concerning this estimate: First, it does not include the sums which the Government would have to contribute annually toward insuring annuitants; second, the administration's frequently stated position is that it cannot at this time acquiesce in spending more than $80 million a year on this program.

(2) Contributions versus benefits:

It can be contended that under section 7(a) contributions of employees and Government may be kept low by setting the rate at a figure less than the maximum authorized amount. But, we are not aware that any carrier has submitted a firm offer to underwrite, at a price less than the maximum contribution rates, the ultrarich benefits which are described in section 5(a)(1) and which are further implied in the Senate committee's report on S. 2162.

In the absence of such firm offer, we have reservations as to whether the implied benefits can be contracted for even at the maximum contribution rates. To the extent that they cannot, or to the extent that Government fiscal policy requires the contribution rates to be set lower than the maximum, the implied ultrarich benefits will have to be curtailed. Any such curtailment in benefits will, like the too-high contribution rates, result in employee disaffection with the program.

We discern other weaknesses in the benefit-contribution structure of S. 2162 but those mentioned above are considered sufficient to justify our recommendation against enactment.

In the absence of a written commitment from a reputable carrier containing detailed specifications of benefits and subscription charges, we believe it wiser not to mislead employees into believing that they will receive ultrarich benefits. It would be infinitely better to delete section 5 of the bill in its entirety and rely on the Commission to negotiate contracts which will provide employees with generally better benefits than they now can get, at a cost to them which, depending on the geographic area, may be less than or about the same as they now pay.

We believe that, to assure enactment of a program, section 7(a) should limit the Government's total contribution to an amount which is acceptable to the administration. And, further, to permit employees who may be so inclined to enroll in plans offering very rich benefits (e.g., some existing group-practice plans) at a subscription charge greater than the maximum contribution rate stipulated in section 7(a), no limit on the employee's contribution rate should be specified. Suggested language to accomplish both these points follows:

[*21] "SEC. 7(a)(1) The Government's contribution to the subscription charge for each enrolled employee or annuitant shall be 33-1/3 % per centum of the subscription charge but may not exceed (i) 95 cents biweekly if he is enrolled for himself alone, or (ii) $2.30 biweekly if he is enrolled for himself and members of his family, or (iii) $1.35 biweekly in the case of a female employee or annuitant who is en-

rolled for herself and members of her family, including a nondependent husband.

"(2) There shall be withheld from the salary of each employee or annuity of each annuitant enrolled in a health benefits plan under this Act so much as is necessary, after deducting the Government's contribution, to pay the subscription charge for his enrollment."

CONTRACTING AUTHORITY

Section 6 authorizes the Commission to negotiate contracts with qualified carriers. It enumerates some of the items to be specified in the contracts but offers no guidance—nor does the Senate committee's report on S. 2162—on what we regard as a critical issue: Should each carrier of a Government-wide plan assume the total risk under his contract or should he be required to share his rights and obligations with other insurers?

For several reasons, but primarily to simplify negotiations with prospective carriers, the Commission considers it highly desirable that the prime carriers' rights and obligations under the two Government-wide plans be shared in much the same manner as the Congress has provided under the Federal Employees' Group Life Insurance Act. While the Commission, in contract negotiations, would probably insist on such sharing even if section 6 were enacted in its present form, it would be preferable to have the Congress express its intent in this regard by including language along the following lines in section 6, perhaps as a new subsection (b):

"(b)(1) The contract for the Government-wide service benefit plan shall require the carrier to allocate its rights and obligations under the contract

among all its affiliates who elect to participate in accordance with an equitable formula to be determined by the carrier and its affiliates and approved by the Commission.

"(2) To be eligible as the carrier for the Government-wide indemnity benefit plan, a company must be licensed to issue group health insurance in all the States and the District of Columbia. The policy for such plan shall require the carrier to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance claims paid in the United States during the latest year for which such information is available, to be determined by the carrier and approved by the Commission."

The Commission assumes, of course, that the national Blue Cross-Blue Shield organization will be the prime carrier for the Government-wide service benefit plan. To eliminate all but a dozen or so of the largest, most responsible insurance companies from consideration as prime carrier of the indemnity benefit plan, and to avoid diversity of citizenship difficulties in the event of a court action by an employee, the suggested language requires the prime carrier to be licensed in all the States and the District of Columbia. All other companies which write group health insurance would, of course, be eligible to acquire their fair share of reinsurance from the prime carrier.

[*22] HEALTH BENEFITS FUND

I am sure your committee is aware that increasing use of hospital and other health services and the continuing rise in the cost of these services has re-

quired many insuring organizations to raise their subscription or premium rates. Some organizations have had to raise their rates several times within the last few years. The current situation in New York City, where the Blue Cross has very recently announced a substantial increase in its rates for the second time in less than 2 years, is characteristic of the trend toward higher insurance costs. Also characteristic is the reported widespread dissatisfaction with the rate increases among subscribers.

Informed opinion is to the effect that steady increases in the cost of providing health services are inevitable. To avoid the necessity of having to increase contribution rates under the Government-sponsored program with unnecessary frequency and, incidentally, to avoid the employee dissatisfaction and the administrative difficulties entailed in each such rate increase, the Commission believes that an adequate contingency reserve should be set aside which could be drawn upon to stave off frequent contribution rate increases. Section 8 of S. 2162 makes no provision for setting aside funds for this purpose other than those derived from "dividends, premium rate credits or other refunds." These refunds (and there is nothing to guarantee that any will be made by the carriers) are completely inadequate for use as a contingency reserve.

The Senate committee, in page 18 of its report on S. 2162, seems to have recognized the need to stabilize contributions by setting aside a portion of contributions as a reserve. It indicates that the reserve shall "not * * * exceed approximately 3 percent of any one year's contributions or [exceed] an accumulative total of approximately 10 percent." However there is no language in section 8 which would au-

thorize retention of any portion of the contributions as a reserve, much less the specific percentages indicated in the Senate committee's report. In view of the explicit authorization in section 8 to set aside a 1 percent reserve for administrative expenses, we question the propriety of setting aside a larger contingency reserve without explicit authorization.

Increases in the cost of health services cannot, of course, be forecast with precision over a long period of years. The Commission feels rather strongly, however, that a contingency reserve should be accumulated which will be adequate to stave off increases in contribution rates for at least the first 5 years of the program's existence and, if possible, longer. To the best of our ability, we have estimated that to do this, it will necessary to set aside moneys up to a maximum of 10 percent of all contributions paid into the fund. Suggested language for amending section 8 to permit the setting aside of an adequate reserve follows:

SEC. 8. (a) There is hereby created a Federal Employees Health Benefits Fund, hereinafter referred to as the "Fund," which is hereby made available without fiscal year limitation for the payment of all subscription charges or premiums under contracts or policies entered into or purchased under section 6. The contributions of employees, annuitants, and the Government toward the subscription charges shall be paid into the Fund. [*23]

"(b) Portions of the subscription charges contributed by employees, annuitants, and the Government shall regularly be set aside as follows: (1) a percentage, not to exceed 1 per centum of all such contributions, determined by the Commission as reasonably adequate to pay the administrative expenses made

available in section 9; (2) for each plan, a percentage, not to exceed 10 per centum of the contributions toward such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. The income derived from any dividends, premium rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future subscription charges, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such reserves are derived, as the Commission shall from time to time determine.

"(c) The Secretary of the Treasury is authorized to invest and reinvest any of the moneys in the Fund in interest-bearing obligations of the United States and to sell such obligations of the United States for the purposes of the Fund. The interest on and the proceeds from the sale of any such obligations shall become a part of the Fund."

ADVISORY COUNCIL

The Commission believes that an advisory council can be a valuable adjunct to the health insurance program. Conversely, a council could operate to hamper administration of the program.

In our considered opinion, two features of section 12 will seriously impair efficient operation of the program.

(1) Composition:

The 11-member Council called for by S. 2162 is so large as to inhibit unified and timely action which may be required of it.

Of the members mentioned in clauses (1) through (7) of section 12(a) only the Director of the Bureau of the Budget, because he is concerned with Government fiscal policy, and the three representatives of employee organizations have a continuing intrinsic interest in the program. We do not see that the other members mentioned (the Secretary of Labor, the Surgeon General, the Chief of the Bureau of Medicine and Surgery, a representative of the public, and three representatives of universities) have more than a casual interest in or concern with the program nor what long-range purpose would be served by their permanent membership on the Council. In any event, the services and advice of any or all these persons could be readily obtained when, in a particular situation, it was considered desirable.

We would suggest that section 12 be amended to create a smaller, more efficient Council whose membership would be representative of the vital interests affected by the program. This membership should, in our opinion, consist of the Director of the Bureau of the Budget, the Secretary of the Treasury, because he is charged by S. 2162 with the management of the health benefits fund, the Secretary of Health, Education, and Welfare, because he is officially concerned with public health and health benefits and, finally, to represent employees' interests, two elected officers of employee organizations and two insured employees at large. [*24]

(2) Duties:

Three of the Council's duties prescribed by section 12(b) are sufficiently inappropriate for an *advisory* council to repeat and comment on here:

(a) "to make studies from time to time of the operation and administration of this Act."

This prescribed duty is sheer duplication of what the Commission is required to do by section 11(a)—"[to] make a continuing study of the operation and administration of this Act."

(b) "to receive reports and information with respect [to this Act] from the Commission, carriers and employees and their representatives."

This duty will (1) interpose the Council between the Commission and the carriers and impair the carriers' accountability to the Commission and (2) make the Council a forum for airing employee grievances. Even if S. 2162 did not require it, the Commission would, as a matter of course, furnish reports and information to the Council and otherwise keep it current with developments so that it would have a basis on which to furnish advice and make recommendations.

(c) "to ascertain from time to time the status of the Federal Employees Health Benefits Fund, including the establishment and maintenance of any balances and reserves."

The Commission, as trustee of the fund, would do just this on a continuing basis and its efforts in this regard would automatically be audited by the General Accounting Office.

We cannot help but feel that, especially at the outset of the program, the Advisory Council as constituted by section 12 would have to be in virtually continuous session, would divert the energies and resources of the Commission, and, in general, would impede efficient administration. We urge that section 12 be amended so that it provides for a council

whose function will be to advise and to recommend rather than to monitor the Commission. Language which would do this follows:

"SEC. 12. (a) There is hereby established a Federal Employees Health Benefits Advisory Council which shall consist of the following:

"(1) The Director of the Bureau of the Budget or his representative;

"(2) The Secretary of the Treasury or his representative;

"(3) The Secretary of Health, Education, and Welfare or his representative;

"(4) Four members, to be appointed by the Chairman of the Commission, of whom two shall be elected officers of national employee organizations and two shall be employees enrolled under this Act.

"(b) It shall be the duty of the Advisory Council (1) to consult with and advise the Commission in regard to the administration of this Act, and (2) to make recommendations to the Commission with respect to the amendment of this Act or improvements in its administration.

"(c) Members of the Council who are not otherwise in the employ of the United States shall be entitled while attending meetings of the Advisory Council, including travel time, to receive compensation at [*25] a rate to be fixed by the Commission, but not exceeding $50 per diem, while away from their homes or regular places of business.

"(d) The Advisory Council shall be convened once yearly or oftener on the call of the Chairman of the Commission or on request of any three members of the Advisory Council."

STATUTORY BUREAU OF RETIREMENT AND INSURANCE

The only reasons we know of for the inclusion of section 13 in S. 2162 are the ones advanced in page 19 of the Senate committee's report on the bill. To put it briefly, the Commission does not find these reasons persuasive.

It is quite possible that the Commission may find it advisable to organize a bureau to handle its retirement and insurance functions. This possibility exists whether S. 2162 is enacted or not. The Chairman of the Commission is already empowered by law to reorganize the Commission and if considerations of economy and efficiency should in the future so dictate, he would do this. But his right, among other things, to choose a propitious time for the reorganization, to assign a name to a newly created bureau, to delegate responsibility, and to determine, in accordance with position classification standards, the grade of a bureau director should not be invaded by a statute which is not germane to these matters.

We must strongly urge that section 13 be deleted entirely from S. 2162.

CONTRACTS AND REGULATIONS

The last feature to which the Commission feels obliged to object is the directive in section 16(a) which would require the Commission to transmit by May 1, 1960, to the House and Senate Committees on Post Office and Civil Service, copies of the contracts it proposes to enter into and the regulations it proposes to promulgate.

We cannot perceive nor have we been able to ascertain the purpose of this directive unless it is to assure that the Commission takes timely action to implement the enacted bill. If this is its purpose, its

inclusion in the bill is superfluous since section 16(b) directs that the enacted bill become effective July 1, 1960. If the bill is enacted, we will of course deploy all our resources to have implementation completed by that date. We feel, in this connection, that it is necessary only to call attention to the very prompt action the Commission took in August of 1954 to make the Group Life Insurance Act effective—and this with no effective date specified in the statute.

In addition to being superfluous, section 16(a) would leave the Commission in a quandary in at least two respects.

(1) Prudence would seem to dictate that the Commission, having transmitted copies of the contracts and the regulations, postpone their signing and promulgation while it awaited some formal acknowledgement from both the Senate and House committees that they had objections to or that they approved of the proposed contracts and regulations. The wait could of course result in significant delay but any action, either negative or affirmative, on the part of either committee could be construed as an infringement upon the Executive's powers. [*26]

(2) If between the time copies of the contracts and the regulations were transmitted and the time they were signed and promulgated, changes were made in either or both, the Commission would presumably have to notify the committees of the changes and again await acknowledgements. Such last minute changes could easily occur after May 1, 1960, in which case the Commission could, involuntarily, be in violation of section 16(a).

Viewed in the most favorable light, section 16(a) is superfluous and enigmatic. It should be deleted from the bill.

We are not in this statement of our views suggesting language to perfect a number of relatively minor items in S. 2162 which we think can (and should) be easily improved. Mostly, these improvements would facilitate administration of the program.

I would be glad to have a representative of my office meet with your staff to work out these perfecting changes and, if you wish, to provide such other technical assistance as your committee may want.

The Bureau of the Budget advises that there is no objection to the submission of this statement to your committee.

By direction of the Commission:

Sincerely yours,

ROGER W. JONES, *Chairman.*

OFFICE OF THE POSTMASTER GENERAL,
Washington, D.C., July 28, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of this Department on S. 2162, as amended and reported in the Senate. S. 2162 is a

bill to provide a health benefits program for Government employees.

In previous years the Post Office Department has favored in principle health insurance for Federal employees, provided such insurance could be obtained at a reasonable cost and meets the needs of employees for protection against catastrophic illness. This Department continues to favor such health insurance for Federal employees.

S. 2162 as reported in the U.S. Senate is based on a committee print. The position of the administration on this legislation has been set forth in reports by the Civil Service Commission and by the Bureau of the Budget (pp. 24-28 of S. Rept. 468 to accompany S. 2162). These reports have been brought to the attention of this Department and this Department concurs therein.

It is understood that the U.S. Civil Service Commission and the Bureau of the Budget will file reports with your committee with respect to S. 2162 as reported to the Senate. In the circumstances, this Department has no comments or recommendations to submit with respect to this legislation.

The Bureau of the Budget has advised that there would be no objection to the submission of this report to the committee.

Sincerely yours,

E. O. SESSIONS,
Acting Postmaster General.

[*27] DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,

August 12, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to your request of July 8 for our comments on S. 2162, as passed by the Senate, a bill to provide a health benefits program for Government employees.

Our comments on S. 2162 are also applicable to H.R. 8210 and H.R. 8211, pending before your committee, which appear to be identical with S. 2162.

In view of the detailed explanation of S. 2162 in the report of the Senate Committee on Post Office and Civil Service, we refrain from burdening this report with a summary of the bill.

The pattern of health insurance coverage for Federal employees proposed by this bill is one which this Department considers appropriate and essential, both to meet the health insurance needs of Federal employees and to assure the competition among plans necessary for expansion of voluntary health insurance in the Nation. In this connection, we should like to mention the following basic points:

1. The employee options permit a real choice of coverage by the employee in terms of what he considers best suited to his needs and those of his family, and also provide an opportunity for the development of enrollment procedures which will yield the kind of educational efforts required to promote re-

straint and responsibility in the use of health insurance benefits. Carriers have found such efforts necessary with regard to both the insured and the providers of services.

Employee choices call for reasonable opportunity for changing from one plan to another. If the rules regarding transfer from one plan to another are unduly restrictive, a valuable gage of employee satisfaction and carrier performance can be lost. Since the bill forbids restrictions which would exclude or limit coverage for preexisting diseases or conditions, the main problems in working out reasonable transfer arrangements will be adjustments for premium payments and benefits already availed of during the previous part of the benefit year.

2. The alternative types of plans set forth in the bill permit the development of benefits which could provide full scope of protection for Federal employees. It should be the responsibility of the Commission to see that each of the plans for which it contracts or gives approval offers protection which is substantially equivalent to some desirable level established by the Commission as a yardstick. Important, too, is the opportunity provided under the bill for women employees to gain coverage for their families.

3. The bill accepts the principle of uniform contributions for both active employees and retirees and uniform benefits for these groups. The continuation of protection for retired employees without reduction—with premiums to continue at the same level, and their cost to be shared by the annuitant and the Government in the same proportion, as for active employees—follows a desirable pattern of coverage in health insurance plans generally.

4. The bill permits the setting aside of a portion of the health benefits fund as a special reserve against adverse fluctuations in future charges. A reserve of this type appears wholly appropriate in view [*28] of the nature of health benefits risk and the rising trend in medical care costs.

On such matters as the desirable distribution of premium costs as between the Government and employees, the composition and functions of the Advisory Council, and the proposed establishment of a Bureau of Retirement and Insurance within the Commission, we defer to the views of the Civil Service Commission. We suggest, however, that the Secretary of Health, Education, and Welfare be designated as a member of the Council in place of the Surgeon General of the Public Health Service. It should be noted that our Social Security Administration and the Office of the Special Assistant to the Secretary on Health and Medical Affairs, as well as the Public Health Service, are expert in and concerned with the study and encouragement of voluntary prepayment plans for hospital, medical, and other health services.

We, therefore, recommend enactment of the bill, with the modifications above suggested, and with such further modifications as are indicated by the views of the Civil Service Commission and the Bureau of the Budget, on the Federal share of the costs, on administrative organization, and on the composition and functions of the Advisory Council.

In making this recommendation, we have not overlooked the fact that the bill does not address itself to the problem of health insurance for those who are already retired, a fact that has given us much concern. We consider it essential that legislation for

active employees and future retirees be supplemented in the near future by providing similar protection for those already retired. While we recognize the complexity of the problems involved in providing effective health benefit coverage to those already on annuities, the pressing health insurance needs of retired Federal employees suggest the importance of an early formulation of ways and means to meet their problems.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

ARTHUR S. FLEMMING, *Secretary.*

GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE,

Washington, D.C., August 7, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of the Department of Defense on S. 2162, 86th Congress, a bill to provide a health benefits program for Government employees, as reported in the Senate on July 2, 1959.

This bill would provide generally for four basic types of health insurance plans to be made available to Federal employees and annuitants, and members of their families. The bill also covers the level and pattern of benefits to be provided under the various

plans; places certain responsibilities in the Civil Service Commission for overall administration; provides for payroll deductions and matching contributions by the Government; establishes a Federal Employees' [*29] Health Benefits Fund; and creates a Federal Employees Health Benefits Advisory Council and states its duties.

The Department of Defense fully recognizes the importance of group health insurance for its employees. For many years it has encouraged these employees to participate in available group health insurance programs on a voluntary basis, and large numbers are currently participating in such programs. This Department has also consistently supported recommendations for health insurance which have been included in the legislative programs of this administration.

The Department of Defense therefore endorses the basic purposes of S. 2162 and favors the enactment of legislation which will establish a Federal employee health benefits program that will provide sound protection against the high costs of illness at a price which both the employees and the Government can afford. The Department further believes that July 1, 1960, should be the goal for making such program fully effective and removing the unfortunate lag between the Federal Government and private industry in this important area.

Time has not permitted the full and detailed analysis of all the technical provisions of S. 2162 which would be necessary in order to determine whether changes in any of those provisions might produce improvements. However, the Department of Defense considers that this bill does provide the ba-

sis for a sound, well-rounded program of health insurance.

From the standpoint of assuring the most economical and efficient administration of this program, however, the Department of Defense is concerned with those provisions of S. 2162 which establish and prescribe the functions and duties of the Federal Employees Health Benefits Advisory Council.

The wording of section 12 makes this Council much more than an advisory body. It has monitoring and investigative functions, may receive reports and information from various individuals concerned with the program (which to some degree at least give it the character of a grievance committee), and may recommend legislation, presumably with or without concurrence of the Civil Service Commission which is the agency responsible for the program.

All these powers and duties of the Advisory Council will, in the opinion of the Department of Defense, tend to dilute and impair the position of the Civil Service Commission as the administrator of the program, create confusion, and make more complicated the administration of a program which will be complicated enough even under the best of circumstances. It is the belief of the Department of Defense that the Advisory Council should be confined to those functions which the name implies—advising and making recommendations to the Civil Service Commission.

It would also seem unnecessary and undesirable to provide for membership on the Council of representatives of university schools of medicine, hospital administration, and public health. While these are undoubtedly sources from which the Civil Service

Commission would desire to seek information and advice from time to time, this can be done without providing membership and votes on a statutory advisory council. Their interest in and identification with the program established by S. 2162 is not this direct.

S. 2162 provides for an equal sharing by employees and the Government of contributions under the program, which exceeds the maximum [*30] Government contribution previously recommended by the administration. It is estimated that costs to the Department of Defense from legislation of this nature will approximate one-half the costs to the Government, exclusive of costs attributable to coverage of annuitants. Since S. 2162 represents pending legislation, no provision has been made for these costs in the budget of the Department.

The Bureau of the Budget advises that there is no objection to the submission of this report to the Congress.

Sincerely yours,

L. NIEDERLEHNER,
Deputy General Counsel.

COMPTROLLER GENERAL OF THE UNITED STATES,

Washington, July 21, 1959.

HON. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service, House of Representatives.

DEAR MR. CHAIRMAN: In compliance with your request of July 8, 1959, we offer our comments on S. 2162, as passed by the Senate.

The bill provides generally that there shall be made available to Government employees health benefit plans of the currently popular types, the cost of which will be borne equally by the Government and the employees concerned. The program will generally give Government employees protection equivalent to that enjoyed by commercial and industrial employees.

While the bill involves a matter of policy upon which we offer no recommendation, the following observations are made for such consideration as they may warrant.

Section 2.—Many terms appearing in the bill, some of which are used interchangeably, are not clear. Among these are hospital care, hospital benefits, medical services, ambulatory patients, hospital services, hospital outpatient, other ambulatory patients, diagnostic and treatment services, and professional services. We assume that the Commission will include in its regulations such definitions as may be necessary.

Section 5 (general comments on subsections (a) and (b)).—Subsection (a) provides the benefits to be included in health plans but subsection (b) authorizes the Commission to substitute "alternative" benefits for any and all of the benefits specified in subsection (a). As the section is now written, the alternative benefits could be exclusive of major medical care. We suggest that subsection (b) be revised to insure that the alternative benefits shall include both basic and major medical protection at least equal to that provided under subsection (a). Also, in the event the Commission finds, in the administration of the program, that costs are being adversely affected by excessive or unjustified use of health services, there

may be required some means of protecting the interests of the employees who refrain from such practices. Possibly, as an aid to the Commission, the authority to include deductibles and coinsurance could be made applicable to any benefits offered by the program.

Section 5(a)(1)(A).—While there is general provision for 120 days hospital care, the duration of care provided in cases of tuberculosis and nervous and mental conditions is limited to 30 days. We think [*31] that the supplemental benefits would apply in these cases, immediately after the expiration of 30 days. However, the relationship of this section to the major medical care provided in section 5(a)(1)(E) is not entirely clear. Therefore, we suggest the insertion of an express provision in the bill designating the point at which a tuberculosis or mental patient would be covered by major medical care.

Section 5(a)(1)(B) and 5(a)(1)(C).—The language "to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes" apparently is intended to preclude graduated medical and surgical fees to Federal employees with incomes less than those in the one-quarter group of employees that earn the highest incomes. However, enactment of the language would constitute congressional recognition of the practice of graduated medical and surgical fees to personnel with incomes in the "one-quarter of Federal employees earning the highest incomes." We doubt that congressional recognition should be given to the practice of graduating medical and surgical fees upon the basis of income. Therefore, you may wish to delete the language in the section relating to graduated fees.

Section 5(a)(1)(D).—Benefits for ambulatory patients should be clarified. As the subsection now reads, it is not clear whether it was the intention to require that each of the four plans specified in section 4 include provisions for protection against medical costs for ambulatory patients, or whether care for this class of patients would be restricted to service benefit plans. Further, it is not clear whether the contemplated medical costs would apply to visits of patients to the physician's office when the patient had not been previously hospitalized for the condition subsequently treated at the office. It is likewise not clear whether the section contemplates the payment for house calls made by physicians.

Section 5(a)(1)(E).—The section provides for a sharing of the first $1,500 of expenses and that the carrier shall pay all costs in excess of $1,500 subject to maximums determined by the Commission. Your committee may wish to consider the desirability of prescribing in the law itself maximum and minimum amounts that would be payable in addition to the first $1,500. This point would be of particular significance if the cost of benefits provided under a plan should increase to a point where it may be necessary for the Commission to reduce certain of such benefits to stay within the limit of available funds.

Also, we suggest the addition of the following language to be inserted after the word "subparagraph" appearing on line 10, page 31, "shall include any and all diseases but".

Section 5(a)(1)(F).—Apparently under this paragraph no supplemental benefits would be provided for any normal delivery even though complications may develop prior to the patients' complete recovery.

Section 5(a)(2).—We do not have the details of the benefits which may be offered under the indemnity plan. We recommend, however, that the bill require or, at least, that the committee report specify that the value of benefits under the indemnity plan generally coincide with the value of the services furnished under the service plan, including coverage of all diseases.

Section 6.—The bill specifies that the Commission shall approve two nationwide plans, one of the service type and one of the indemnity type, and authorizes the Commission to enter into nationwide con-[*32]tracts for benefits provided by the two plans. Under such conditions the question arises as to what recognition is to be given to the variations in hospital room rates, medical services, and surgical fees between various localities. Since schedules of benefits will be applicable nationwide, there will be a tendency for those hospitals and surgeons heretofore charging less than the stated maximum to increase their rates and fees until they reach the maximum levels specified. This result would add to the cost of the program for both the employee and the Government. In our opinion the bill should specify that the nationwide contracts contain language assigning to the carrier responsibility for maintaining costs at prevailing local levels. We suggest language similar to the following be added to section 6(b) "Any nationwide prime contract shall include a requirement that the carrier's subcontracts or other arrangements with corporations, associations, groups, doctors, hospitals, and other providers of health services shall be stated at cost levels no higher than the (1) charges to the general public, or (2) schedules of health benefit costs in local health benefit plans."

We suggest that this section be amended to authorize the Commission to require reinsurance if it deems such action is necessary to protect the interests of the Government. Similar reinsurance is required under the Government Employees Life Insurance Act.

Section 7(b).—This section covers employees who are on leave without pay and would vest in the Commission discretion to regulate the coverage to be granted. Presumably, this discretion is necessary to enable consideration of the circumstances involved in individual cases concerning authorized or unauthorized leave without pay. Consideration might be given to providing the Commission guidelines for its administration of this section in your committee's report.

Section 8.—We recommend a technical revision in this section. After the word "Fund" on page 36, line 14, insert the language "which shall be administered by the Commission and". Also, on page 37, after the word "Fund" appearing on line 15, insert the language "when directed by the Commission."

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

COMPTROLLER GENERAL OF THE UNITED STATES,

Washington, August 17, 1959.

B-119033.

Hon. TOM MURRAY,

Chairman, Committee on Post Office and Civil Service,

House of Representatives.

DEAR MR. CHAIRMAN: As a result of a number of conferences between members of our respective staffs we have been requested to report on the version of the bill S. 2162 presently under consideration by your committee. We are pleased to offer the following comments on the bill as presently revised by the committee.

Health benefit plans (sec. 4, p. 30)

Section 4 of the bill provides that there shall be one Government-wide service benefit plan and one Government-wide indemnity plan. **[*33]** Testimony before the committee has disclosed clearly that in order to provide a health plan within the reach of the employees in the lower grades, and for basic fiscal policy reasons, a benefits plan with relatively low or "thin" benefits will be acquired. Under the requirement that only one service and one indemnity plan may be operative, such plans may and probably will not provide a benefit level desired by the majority of employees in the middle or upper grades, nor will the new uniform medium or low benefit plan compare favorably with broader coverage now carried by many employees. We suggest that the committee consider revising this section of the bill to require the providing of at least two levels of benefits for each of the two primary plans created by sections 4(1) and 4(2). Two levels of benefits would provide a more flexible choice to the employees, enabling them to consider local cost conditions, and would also recognize the employees' ability to pay. In our opinion the option for two levels of benefits under each major plan could be included within a single contract with the respective carriers. While the cost of administration will necessarily be increased by additional op-

tions, we believe that the matter can be worked out by the Commission to assure a minimum of increased costs. The following language, or some modification thereof, added to sections 4(1) and 4(2) would provide a basis for the Commission to develop two levels of benefits and two levels of cost under each of the two nationwide plans:

"*Provided*, That any such plan shall include two levels of benefits and two related levels of subscription or premium charges."

Contracting authority (sec. 6, p. 38)

The committee has received testimony that experience under many health plans indicates they are subject to costly abuses. Published material indicates a rather significant overutilization of hospital services when the individuals are insured for hospital services only. Some published data has indicated that unnecessary hospitalization under insurance or service plans runs as high as 20 percent.

If abuses occur, then costs borne by the employee and the Government will be correspondingly higher. Conversely, if the unnecessary services and the related costs are curtailed, then more funds will be available to provide the necessary benefits. The unnecessary use of hospital room and board in order to obtain other needed services not available unless the patient is hospitalized, is an example of abuse. The insurance industry and the large employers have devised contract provisions designed to curtail nonessential utilization of health services, and it would seem that where appropriate the Government should apply similar and other effective provisions. Coverage of all medical services, coupled with coinsurance and deductibles are among the corrective devices

used. The committee may wish to state in the bill an expression of policy for the guidance of the Commission in framing contracts to provide to the extent possible for the curtailment of abuses of the Government health plans by the users of the services or benefits. This could be accomplished by adding a provision to section 6 of the bill, reading substantially as follows:

"Regulations of the Commission shall require that all plans or contracts include benefits, in specified categories of health services, and at such levels, as the Commission determines necessary to restrict excessive utilization or abuse of any service. The standards shall [*34] include such other provisions, including coinsurance and deductible provisions, determined by the Commission to be necessary to prevent abuses of the program."

Contributions (sec. 7(a)(1), p. 36)

We wish to point out that section 7(a)(1) as written, permits the Commission full discretion regarding the level of benefits that may be acquired. The benefits may be set very low—substantially below the amounts stated in subparagraphs (i) and (ii)—and in such cases the Government would pay 50 percent of the costs. If the benefits acquired are liberal and the costs higher, then the Government may pay less than 50 percent of the costs.

Also, we note that the minimums and maximums between which the Commission must set the "prescribed" amounts are apparently intended to be applicable uniformly to all plans. However, it is possible to interpret the language of this section as authorizing variable "prescribed" amounts, within the three categories of minimum and maximum limits

stated in the bill. We believe this would be inequitable to employees who were members of the plans assigned low "prescribed" amounts. We suggest the following change on line 7, page 36:

"The amounts so prescribed, which shall be uniform for all plans, shall not—."

Subscription charges and premiums

The bill contains numerous references to "subscription charges" and "premiums." However, the manner in which the terms are used indicates that in some instances these terms refer to the combined amount represented by payroll deductions from employees and the Government's transfer to the fund, and in other instances one or both of the terms refer to the payment from the fund to the carriers. These amounts paid into the fund will not necessarily be the same as the amounts paid out to carriers, as the bill is now written. The difference in the amounts is due to allowances for expenses and credits to the reserve. It is suggested that the use of these terms throughout the bill be reviewed and their specific use clarified by editorial change.

We will be pleased to provide any further information or assistance in connection with this proposed legislation that the committee desires.

Sincerely yours,

FRANK H. WEITZEL,
Assistant Comptroller General of the United States.

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94TH CONGRESS 2d Session | HOUSE OF REPRESENTATIVES | REPORT No. 94-1211

PREEMPTION OF STATE LAWS INCONSISTENT WITH FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

JUNE 2, 1976.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. WHITE, from the Committee on Post Office and Civil Service,
submitted the following

REPORT

[To accompany H.R. 12114]

The Committee on Post Office and Civil Service, to whom was referred the bill (H.R. 12114) to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employees health benefits and coverage provided pursuant to contracts made wider such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

On the first page, beginning on line 8, strike out "payment, nature, or extent of benefits or coverage"

and insert in lieu thereof "nature or extent of coverage or benefits (including payments with respect to benefits)."

EXPLANATION OF AMENDMENT

The committee amendment merely improves the grammatical structure of the bill.

PURPOSE

The sole purpose of H.R. 12114 is to establish uniformity in benefits and coverage under the Federal Employees' Health Benefits Program by providing that the provisions of any contract under such program shall supercede and preempt any State or local law or regulation that is inconsistent with such contractual provisions.

COMMITTEE ACTION

H.R. 12114, as amended, was ordered reported by voice vote of the Committee on Post Office and Civil Service on May 6, 1976. Public hearings on H.R. 12114 were conducted by the Subcommittee on Re-[*2]tirement and Employee Benefits on March 23 and 25, 1976 (Hearing No. 94–69). On April 28, 1976, the Subcommittee, by unanimous voice vote, approved H.R. 12114, with a technical amendment, for full committee consideration.

BACKGROUND

The Federal Employees' Health Benefits (FEHB) Program, established by the Federal Employees' Health Benefits Act of 1959, now codified in chapter 80 of title 5, United States Code, provides health insurance coverage for about three million Federal employees and annuitants and six million dependents. The contracts negotiated between the Civil Service Commission and the various FEHB carriers

are required to provide the same benefits for the same premium for all enrollees in a particular plan. The contracts specify the benefits to be provided by the various plans and the premium cost which is shared by the Government and the enrollees.

The total cost of the program in fiscal year 1974 was approximately $1.6 billion of which amount the Government contributed approximately $960 million. The total cost of the program for fiscal year 1976 will be about $2 billion.

On February 20, 1975, the Honorable Richard C. White, Chairman of the Subcommittee on Retirement and Employee Benefits, requested the Comptroller General of the United States to furnish a report identifying those State health insurance requirements which conflict with contracts negotiated between the FEHB carriers and the Civil Service Commission. On October 17, 1975, the Comptroller General submitted his report (B–164562) which discusses the various State conflicts, the carriers' methods of dealing with these conflicts, and the position of the Civil Service Commission and certain carriers regarding the applicability of State requirements to the FEHB contracts. In addition, the Comptroller General found that—

(1) Some doubt and confusion exists among the carriers and the States regarding the applicability of State requirements to FEHB contracts, and

(2) The States are becoming increasingly active in establishing and enforcing health insurance requirements.

As a result of his findings, the Comptroller General recommended that the Subcommittee consider

legislation to clarify the applicability of State insurance requirements to FEHB contracts. Pursuant to the Comptroller General's suggestion, Chairman White introduced H.R. 12114.

STATEMENT

The Subcommittee's hearings on H.R. 12114 confirmed the finding of the Comptroller General that there exists much doubt and confusion on the part of the carriers and the States regarding the applicability of various State health insurance requirements to the Federal Employees' Health Benefits contracts. As a result, decisions regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits Program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Some States have established health insurance requirements that conflict with the provisions of the FEHB contracts, such as requiring recognition of certain practitioners not covered by Federal Employees' [*3] Health Benefits plans. Many States have not attempted to enforce their requirements that conflict with the FEHB plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program.

For example, the Indemnity Benefit Plan (Aetna) pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State laws require coverage for such

services. The Services Benefit Plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropractic services.

Some plans have requested the assistance of the Civil Service Commission in obtaining exemptions from the State requirements, but the Commission has consistently taken the position that the States now have the authority to regulate the plans.

The cost of revising the carriers' contracts with the Civil Service Commission to include all benefits required by States is difficult to estimate because of such unknown factors as the potential utilization of these benefits. However, representatives of Aetna Life and Casualty (the Indemnity Benefit Plan) believe that they would have to increase their premiums by as much as five percent to cover such benefits.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with provisions of FEHB contracts, these conflicting requirements can be expected to result in:

Increased premium costs to both the Government and enrollees and

A lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

In view of the doubt and confusion that exists among the health benefit carriers and many States, the increased activity of the States in establishing and enforcing health insurance requirements, and the necessity and desirability of providing uniform coverage for all enrollees in each option of each plan, the committee strongly recommends enactment of H.R. 12114.

The Administration supports the enactment of H.R. 12114. In that regard, it is the view of the Administration that the Federal Employees' Health Benefits Program—a program established by an Act of Congress—should not be subject to alteration or regulation by State legislatures or State insurance boards. The committee fully concurs in this view.

ANALYSIS OF H.R. 12114

H.R. 12114 amends section 8902 of title 5, United States Code, relating to contracts for Federal employee health benefits plans, by adding a new subsection (1) at the end thereof. The new subsection provides that the provisions of any health benefits contract under chapter 89 [*4] of title 5 which relate to the nature or extent of coverage or benefits, including payments with respect to benefits, shall supersede and preempt any State or local law, or any regulation issued under such law, relating to health insurance or plans, to the extent that such law or regulation is inconsistent with the provisions of the Federal employees' health benefits contract. The effect of this amendment is to preempt the application of State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage when such laws or regulations conflict

with the provisions of contracts under the Federal Employees Health Benefits Program. However, the amendment is not intended to apply to State or local laws relating to the taxation of health insurance carriers or to the maintenance of special reserves.

COST

The enactment of H.R. 12114 will not result in any additional cost to the Government. This legislation could result in a savings to the Government since, in the absence of this legislation, the future application of conflicting State and local health insurance laws would result in an increase in Federal employees' health insurance premiums of which the Government now pays approximately 60 percent.

NEW BUDGET AUTHORITY AND NEW SPENDING AUTHORITY

This bill does not provide authority to enter into new obligations which will result in immediate or future outlays involving Government funds, and therefore, the requirements of section 308(a) of the Congressional Budget Act of 1974, relating to a statement on new budget authority, are not applicable to this bill.

H.R. 12114 does not provide "new spending authority" as that term is defined under section 401 of the Congressional Budget Act of 1974, and therefore the requirements of section 401(b)(2) of that Act, relating to new spending authority which may result in new budget authority exceeding the appropriate allocation, are not for application to this legislation as stated above, this bill will not result in any cost to the Government.

OVERSIGHT

Under the rules of the Committee on Post Office and Civil Service, the Subcommittee on Retirement and Employee Benefits is vested with legislative and oversight jurisdiction over the subject matter of this legislation. As a result of the hearings on this legislation, the Subcommittee concluded that there was ample justification for amending the law in the manner provided under H.R. 12114.

The committee received no report of oversight findings or recommendations from the Committee on Government Operations pursuant to clause 2(b)(2) of House rule X.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of House rule XI, the Committee has concluded that the enactment of H.R. 12114 will have no inflationary impact on the national economy.

[*5] AGENCY VIEWS

There are set forth below the reports of the United States Civil Service Commission and the Office of Management and Budget on H.R. 12114.

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., March 22, 1976.

Hon. DAVID N. HENDERSON,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further reply to your request for the Commission's views on H.R. 12114, a bill "To amend chapter 89 of title 5, United States Code, to establish uniformity in Fed-

eral employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

H.R. 12114 would, in effect, exempt the Federal Employees Health Benefits (FEHB) Program from any State or local law or regulation to the extent that such law or regulation conflicted with the provisions of the FEHB contract. This would statutorily establish uniformity of benefits and coverage under the FEHB Program and the Commission strongly urges favorable consideration of the bill.

The Federal Employees Health Benefits Act, now codified in chapter 89 of title 5, United States Code, gives the Commission sole authority to negotiate contracts with participating carriers, and to prescribe regulations to implement its provisions. However, the FEHB law contains no clear statement which would authorize the Commission to prescribe regulations restricting the application of state laws in relation to the Commission's health benefits contracts.

All states regulate the insurance business in various (and varying) ways. Apparently, in the early years of the FEHB Program, FEHB plans were either in compliance with these laws, or the laws excluded FEHB plans, or the states elected not to enforce laws that conflicted with FEHB plans. Whatever the reason, state laws offered few if any problems for our program.

In the past several years, however, more and more states have legislated the kinds of benefits and medical practitioners that carriers doing business in

these states must cover. This presents a very real danger to the uniformity of benefits under the FEHB program. For example, the Aetna Life and Casualty (carrier of the Government-wide Indemnity Benefit Plan) is currently being compelled to pay for the services of chiropractors in several states, even though our contract with Aetna does not recognize these practitioners as covered providers. If they refused to comply they would lose their license to provide health insurance in those states and would no longer be eligible as the Indemnity Benefit carrier under the FEHB Program, since the law (5 U.S.C. 8902(b)) requires them to be licensed in all 50 states and the District of Columbia.

Aetna contended that such state laws are preempted by the FEHB Act, and asked the Commission's Office of General Counsel to concur in their position that the McCarran-Ferguson Act establishes the preemption inasmuch as McCarran-Ferguson recognizes the authority of [*6] the states to retain the power to regulate the business of insurance, except where an Act of Congress (i.e., 5 U.S.C. chapter 89) "specifically relates to the business of insurance." However, the General Counsel's response to Aetna noted that the FEHB Act, although it authorizes the Commission to enter into contracts with insurers, does not provide that the Commission actually conducts insurance business. They therefore found no legal merit in Aetna's position but, instead, found that the states could indeed regulate our plans.

As a result, numerous states, including some which have previously acknowledged that their laws do not apply to our contracts, are more aggressively pursuing the preemption problem. States are enact-

ing insurance laws affecting not only specific types of care, extent of benefits and specific types of providers, but also family members covered, age limits for family members, extension of coverage, and conversion contracts. Additionally, numerous state laws are being made extraterritorial to overcome our carriers' argument that our contracts are made in the District of Columbia and not in the state.

One of the most beneficial features of our FEHB plans is the requirement that they provide the same uniform benefits for the same premium for all enrollees in a plan. This can no longer be enforced if carriers are compelled to pay extra-contractual benefits in some of the states in compliance with state or local laws.

Presumably, the states have (and now seem to want to exercise) the authority to determine what benefits will or will not be paid, who is a covered medical practitioner, and who is an eligible family member. It is imperative that some action be taken to deal with what is becoming a serious problem. If nothing is done, it is logical to assume that the states rather than the Federal Government will become the final arbiters of what is and is not covered by the FEHB Program.

The Commission has studied various possible solutions to this problem. It is our belief that legislation such as H.R. 12114 preempting the FEHB Program from state or local law offers the only permanent solution. Additionally this appears to be the only solution which would not compromise the principle of uniform benefits for all enrollees in a plan, and which would not result in additional cost to the Government.

For these reasons the Commission strongly urges enactment of H.R. 12114.

The Office of Management and Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

GEORGIANA SHELDON,
Acting Chairman.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., March 23, 1976.

Hon. DAVID N. HENDERSON,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to the Committee's request for the views of this Office on H.R. 12114, "To amend chapter 89 of title 5, United States Code, to establish uniformity in Federal em-[*7]ployee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

The purpose of this bill is to exempt the Federal Employees Health Benefits (FEHB) program from State or local laws or regulations to the extent they conflict with the provisions of an FEHB contract, in

order to ensure that benefits and coverage under the program will be uniform.

In its report and testimony, the Civil Service Commission states a number of reasons for supporting enactment of this bill.

We concur in the views expressed by the Civil Service Commission and, accordingly, recommend enactment of H.R. 12114.

Sincerely,

JAMES M. FREY,
Assistant Director for Legislative Reference.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 8902 OF TITLE 5, UNITED STATES CODE

§ 8902. Contracting authority

(a) The Civil Service Commission may contract with qualified carriers offering plans described by section 8903 of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company

must be licensed to issue group health insurance in all the States and the District of Columbia

(c) A contract for a plan described by section 8093(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Commission; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Commission.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Commission considers necessary or desirable.

(e) The Commission may prescribe reasonable minimum standards for health benefits plans described by section 8903 of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned [*8] without regard to subchapter II of chapter 5 and chapter 7 of this title. The Commission may terminate the contract of a carrier effective at the end of the contract term, if the Commission finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of this first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee or annuitant whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee or annuitant who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Commission, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of

carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter, shall require the carrier to agree to pay for or provide a health service or supply an individual case if the Commission finds that the employee, annuitant, or family member is entitled thereto under the terms of the contract.

(k) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist or optometrist, licensed or certified as such under Federal or State law, as applicable, an employee, annuitant, or family member covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist or optometrist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. The provisions of this subsection shall not apply to group practice prepayment plans.

(l) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

[*1]

95TH CONGRESS *1st Session*

HOUSE OF REPRESENTATIVES

REPORT No. 95-282

PREEMPTION OF STATE LAWS INCONSISTENT WITH FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

MAY 10, 1077.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mrs. SPELLMAN, from the Committee on Post Office and Civil Service,
submitted the following

REPORT

[To accompany H.R. 2931]

The Committee on Post Office and Civil Service, to whom was referred the bill (H.R. 2931) to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment (stated in terms of the page and line number of the introduced bill) is as follows:

Page 1, line 7, strike out "(l)" and insert "(m)".

EXPLANATION OF AMENDMENT

The committee amendment merely corrects an erroneous subsection designation.

PURPOSE

The sole purpose of H.R. 2931 is to establish uniformity in benefits and coverage under the Federal employees' health benefits program by providing that the provisions of any contract under such program shall supersede and preempt any State or local law or regulation that is inconsistent with such contractual provisions.

COMMITTEE ACTION

H.R. 2931 is identical to the bill H.R. 12114 which passed the House on the Consent Calendar during the 94th Congress. In view of the fact [*2] that hearings were held on this proposal during the 94th Congress (see Hearing No. 94-69), no hearings were held on H.R. 2931 this year.

On March 8, 1977, the Subcommittee on Compensation and Employee Benefits unanimously approved H.R. 2931, and on April 27, 1977, the full committee ordered the bill reported by a record vote of 13 to 0.

The administration supports the enactment of H.R. 2931.

BACKGROUND

The Federal employees' health benefits (FEHB) program, established by the Federal Employees' Health Benefits Act of 1959, now codified in chapter 89 of title 5, United States Code, provides health insurance coverage for about 3 million Federal employees and annuitants and 6 million dependents. The

contracts negotiated between the Civil Service Commission and the various FEHB carriers are required to provide the same benefits for the same premium for all enrollees in a particular plan. The contracts specify the benefits to be provided by the various plans and the premium cost which is shared by the Government and the enrollees.

The total cost of the program in fiscal year 1976 was approximately $2.2 billion of which amount the Government contributed approximately $1.4 billion. The total cost of the program for fiscal year 1977 will be about $2.5 billion.

On February 20, 1975, the Chairman of the former Subcommittee on Retirement and Employee Benefits requested the Comptroller-General of the United States to furnish a report identifying those State health insurance requirements which conflict with contracts negotiated between the FEHB carriers and the Civil Service Commission. On October 17, 1975, the Comptroller General submitted his report (B-164562) which discusses the various State conflicts, the carriers' methods of dealing with these conflicts, and the position of the Civil Service Commission and certain carriers regarding the applicability of State requirements to the FEHB contracts. In addition, the Comptroller General found that—

(1) Some doubt and confusion exists among the carriers and the States regarding the applicability of State requirements to FEHB contracts, and

(2) The States are becoming increasingly active in establishing and enforcing health insurance requirements.

As a result of his findings, the Comptroller General recommended that the subcommittee consider legislation to clarify the applicability of State insurance requirements to FEHB contracts.

STATEMENT

The hearings held during the 94th Congress (Hearing No. 94-69) confirmed the finding of the Comptroller General that there exists much doubt and confusion on the part of the carriers and the States regarding the applicability of various State health insurance require-[*3]ments to the Federal employees' health benefits contracts. As a result, decisions regarding health benefits or services required by States, but not covered under the Federal employee's health benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Some States have established health insurance requirements that conflict with the provisions of the FEHB contracts, such as requiring recognition of certain practitioners not covered by Federal employee's health benefits plans. Many States have not attempted to enforce their requirements that conflict with the FEHB plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program.

For example, the Indemnity Benefit Plan (Aetna) pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State law requires coverage for such

services. The Services Benefit Plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropratic services.

As a result of this situation, officials of the Civil Service Commission asked the General Counsel of the Commission to review the law and furnish legal opinion on the question of the dominance of the Federal Employees' Health Benefits law over State and local laws. The General Counsel's conclusion was that, based on the supremacy clause of the Constitution, the Federal Employees' Health Benefits law preempts State-and local laws in this area. While the Commission has adopted the views of its General Counsel, the Commission has advised the committee as follows:

> The Commission adopted the views of the General Counsel that the Federal Employees Health Benefits Act preempts state laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time consuming and costly litigation with the states until its position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health

Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

For these reasons the Commission strongly urges enactment at an early date of H.R. 2931.

[*4] The cost of revising the carriers' contracts with the Civil Service Commission to include all benefits required by States is difficult to estimate because of unknown factors such as the potential utilization of these benefits. However, representatives of Aetna Life and Casualty (the Indemnity Benefit Plan) believe that they would have to increase their premiums by as much as 5 percent to cover such benefits. Further, the Civil Service Commission estimated, in testimony during the 94th Congress, that approximately $125 million is being expended annually for benefits not covered under the FEHB contracts due to the various conflicting State and local laws.

It is clear that States are becoming more active in establishing and enforcing health insurance requirements which conflict with provisions of the FEHB contracts. These conflicting requirements can be expected to result in:

Increased premium costs to both the Government and enrollees, and

A lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

In view of the doubt and confusion that exists among the health benefits carriers and many States, the increased activity of the States in establishing and enforcing health insurance requirements, and the necessity and desirability of providing uiform coverage for all enrollees in each option of each plan, the committee strongly recommends enactment of H.R. 2931.

The administration supports the enactment of H.R. 2931. In that regard, it is the view of the administration that the Federal employees' health benefits program—a program established by an Act of Congress—should not be subject to alteration or regulation by State legislatures or State insurance boards. The committee fully -concurs in this view.

ANALYSIS OF H.R. 2931

H.R. 2931 amends section 8902 of title 5, United States Code, relating to contracts for Federal employee health benefits plans, by adding a new subsection (m) at the end thereof. The new subsection provides that the provisions of any health benefits contract under chapter 89 of title 5 which relate to the nature or extent of coverage or benefits, including payments with respect to benefits, shall supersede and preempt any State or local law, or any regulation issued under such law, relating to health insurance or plans, to the extent that such law or regulation is consistent with the provisions of the Federal employees' health benefits contract. The effect of this amendment is to preempt the application of State laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members, or other matters relating to health benefits or coverage when such laws or regulations [*5] conflict

with the provisions of contracts under the Federal employees' health benefits program. However, the amendment is not intended to apply to State or local laws relating to the taxation of health insurance carriers or to the maintenance of special reserves.

COST

The enactment of H.R. 2931 will not result in any additional cost to the Government. This legislation could result in a savings to the Government since, in the absence of this legislation, the future application of conflicting State and local health insurance laws would result in an increase in Federal employees' health insurance premiums of which the Government now pays approximately 60 percent.

NEW BUDGET AUTHORITY AND NEW SPENDING AUTHORITY

This bill does not provide authority to enter into new obligations which will result in immediate or future outlays involving Government funds, and therefore the requirements of section 308(a) of the Congressional Budget Act of 1974, relating to a statement on new budget authority, are not applicable to this bill.

H.R. 2931 does not provide "new spending authority" as that term is defined under section 401 of the Congressional Budget Act of 1974, and, therefore, the requirements of section 401(b) (2) of that act, relating to new spending authority which may result in new budget authority exceeding the appropriate allocation, are not for application to this legislation.

OVERSIGHT

Under the rules of the Committee on Post Office and Civil Service, the Subcommittee on Compensation and Employee Benefits is vested with legislative and oversight jurisdiction over the subject matter of this legislation. As a result of the hearings on this legislation conducted during the 94th Congress, the subcommittee concluded that there was ample justification for amending the law in the manner provided Under H.R. 2931.

The committee received no report of oversight findings or recommendations from the Committee on Government Operations pursuant to clause 4 (c) (2) of House rule X.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1) (4) of House rule XI, the committee has concluded that the enactment of H.R. 2931 will have no inflationary impact on the national economy.

AGENCY VIEWS

There is set forth below the report of the United States Civil Service Commission recommending enactment of H.R. 2931. **[*6]**

UNITED STATES CIVIL SERVICE COMMISSION,
Washington, D.C., May 9, 1977.

Hon. ROBERT N. C. NIX,
Chairman, Committee on Post Office and Civil Service, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further reply to your request for the Commission's views on

H.R. 2931, a bill "to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts."

H.R. 2931 would exempt the Federal employees health benefits program from any State or local law or regulation to the extent that such law or regulation conflicted with the provisions of the Federal Employees Health Benefits Act, regulations issued or contracts negotiated thereunder insofar as they pertain to benefits and coverage. It would not, as we read it, exempt the insurance carriers under the Federal employees health benefits program from the payment of State premium taxes, State requirements for statutory reserves; or other such regulations pertaining to the regulation of insurance within the State. It is a form of limited preemption.

The bill would statutorily establish uniformity of benefits and coverage under the Federal employees health benefits program as well as solve the other problems encountered in recent years in the administration of the program. The Commission strongly urges favorable consideration of the bill.

All States regulate the health insurance business in various and varying ways. During the early years of the Federal employees health benefits program, our plans and contracts were either in compliance with these laws and regulations or the States elected not to enforce laws that conflicted with our plans. Whatever the reason, State laws offered few if any problems for our program. Over the past several years, however, more and more States have legislat-

ed the kinds of benefits and medical practitioners that carriers doing business in these States must cover. These laws in effect presented serious problems from the standpoint of the uniformity of benefits under the program. It also placed carriers in serious jeopardy of loss of their license in a State unless they were to approve pay for a benefit not provided under our contract but required by State law. The problem was complicated by the fact that if the Indemnity Benefit Plan carrier, Aetna, lost their license to provide health insurance in those States or in any State they would no longer be eligible as a carrier under the Federal Employees Health Benefits law since the law (5 U.S.C. 8902 (b)) requires them to be licensed in all 50 States and the District of Columbia. We would have no Governmentwide Indemnity Benefit Plan. In addition to legislation and regulations applying to the kinds of benefits and medical practitioners that must be recognized, many States went further in requiring not only specific types of care but the extent of benefits, family members to be covered, the age limits for family members, extension of coverage, the format and the type of informational material that must be furnished, including in some instances the type of [*7] language to be used, extension of coverage and the type of conversion contracts that must be offered. The problem was further compounded by numerous State laws being made extraterritorial. The effect of these conflicting State laws had on our program was that if we were to continue or our carriers were to continue to be subject to State law the benefits provided to Federal employees could not be uniform throughout the country and were largely determined on the basis of what State the employee either resided in or worked in. In terms of contracting with the carrier, it was

reaching a point where unless we were to negotiate contracts that included all the requirements of the various State laws and applied them nationwide, we would continue to place our carriers in a position where they would not be in compliance with some State law. In addition, many of the State laws were in conflict with one another. It appeared that under these circumstances the only solution to the problem would lie in negotiating contracts for Federal employees in each State and issuing separate brochures to meet individual State requirements.

Confronted with this situation the General Counsel of the Commission was asked to review the law and furnish a legal opinion on the question of the dominance over State and local laws of the Federal Employees Health Benefits Act. The General Counsel's conclusion was that "the supremacy clause creates an immunity from State interference of Federal operations. The principle underlying the need for national uniformity in the administration of Federal functions operate to supersede conflicts arising from State laws and apply with equal regard to the Commission's administration of the Federal Employees Health Benefits Act. The McCarran-Ferguson Act by its terms and the interpretation of the courts in no way diminishes the supremacy 431 the Federal Employees Health Benefits Act over State laws. If the Commission is to have a free hand it needs to administer the Federal Employees Health Benefits Act, no other conclusion can be reached."

The Commission adopted the views of the General Counsel that the Federal Employees Health Benefits Act preempts State laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time

consuming and costly litigation with the States until its position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

For these reasons the Commission strongly urges enactment at an early date of H.R. 2931.

The Office of Management and Budget advises that from the standpoint of the administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

ALAN K. CAMPBELL,
Chairman.

[*8] CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 8902 OF TITLE 5, UNITED STATES CODE

§ 8902. Contracting authority

(a) * * *

* * * * *

(m) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

[*1]

95TH CONGRESS *2d Session*

SENATE

REPORT No. 95-903

UNIFORMITY IN FEDERAL EMPLOYEE HEALTH BENEFITS AND COVERAGE

MAY 18, 1976 (legislative day, MAY 17), 1978.—
Ordered to be printed

Mr. SASSER, from the Committee on Governmental Affairs,
submitted the following

REPORT

[To accompany H.R. 2931]

The Committee on Governmental Affairs, to which was referred the bill (H.R. 2931) to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with such contracts, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

AMENDMENTS

The amendments are as follows:

Amend the title to read as follows:

To amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage by preempting certain inconsistent State or local laws while recognizing the rights of States to determine who is to provide health services.

On page 1, line 7, strike out "(m)" and insert in lieu thereof "(m) (1)".

On page 2, line 5, strike out the closing quotation marks and the end period.

On page 2, immediately after line 5, insert the following:

(2) (A) Notwithstanding the provisions of paragraph (1), if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health [*2] services for the care and treatment of any particular health condition other than a mental health condition, the carrier shall provide, pay, or reimburse for any such health service properly provided by a person licensed under State law to provide such service.

(B) The provisions of this paragraph shall not apply to group practice prepayment plans.

On page 2, after line 5, insert the following new section:

SEC. 2. Section 8901(8) of title 5, United States Code, is amended by striking out "before January 1, 1964" and inserting in lieu thereof "after December 31, 1978, and before January 1, 1980".

PURPOSE

The purpose of H.R. 2931, as amended, is to establish uniformity in benefits and coverage under the Federal employees' health benefits program by providing that the provisions of any contract under such program shall supersede and preempt any State or local law or regulation that is inconsistent with such contractual provisions. At the same time, however, the purpose is to recognize the rights of States to determine who is to provide health services.

The bill also amends section 8901(8) of title 5, United States Code, to permit an employee organization, as defined under the section, to apply, after December 31, 1978, and before January 1, 1980, to the Civil Service Commission for approval of a health benefit plan.

HEARINGS

Hearings on H.R. 2931 were held by the Subcommittee on Civil Service and General Services on September 14, 1977. Appearing in support of the bill were: Mr. Thomas Tinsley, Director, Bureau of Retirement, Insurance and Occupational Health, U.S. Civil Service Commission; and Mr. Malcolm McIntyre, director, Government Relations Division, Aetna Life and Casualty Co. Appearing in opposition to the bill were: Dr. Robert B. Shelton, president, United Chiropractors of North America; Dr. Paul Parrott, American Chiropractic Association; and Mr. Herbert Anderson, the National Association of Insurance Commissioners.

Thereafter, the subcommittee amended the bill as described above and recommended favorable action by the full committee on the bill, as amended, on May 9, 1978.

BACKGROUND

The Federal employees' health benefits (FEHB) program, established by the Federal Employees' Health Benefits Act of 1959, now codified in chapter 89 of title 5, United States Code, provides health insurance coverage for about 3 million Federal employees and annuitants and 6 million dependents. The contracts negotiated between the Civil Service Commission and the various FEHB carriers are required to provide the same benefits for the same premium for all enrollees in a particular plan. The contracts specify the benefits to be [*3] provided by the various plans and the premium cost which is shared by the government and the enrollees.

The total cost of the program in fiscal year 1976 approximately $2.2 billion of which amount the government contributed approximately $1.4 billion. The total cost of the program for fiscal year 1977 will be about $2.5 billion.

According to the Comptroller General, as documented in his October 17, 1975, report to the Congress entitled 'Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employee Health Benefits Carriers':

(1) some doubt and confusion exists among the carriers and the States regarding the applicability of state requirements to FEHB contracts, and

(2) the States are becoming increasingly active in establishing and enforcing health insurance requirements.

As a result of these findings, the Comptroller General recommended that the Congress consider legislation to clarify the applicability of State insurance requirements to FEHB contracts.

Some States have established health insurance requirements that conflict with the provisions of the FEHB contracts, such as requiring recognition of certain practitioners not covered by Federal employee's health benefits plans. Many States have not attempted to enforce their requirements that conflict with the FEHB plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program.

For example, the indemnity benefit plan (Aetna) pays for chiropractice services in Nevada as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractice services only in New York and Montana where State law requires coverage for such services. The services benefit plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropractice services.

As a result of this situation, officials of the Civil Service Commission asked the General Counsel of the Commission to review the law and furnish legal opinion on the question of the dominance of the Federal Employees' Health Benefits law over State and local laws. The General Counsel's conclusion was that, based on the Supremacy clause of the Constitution, the Federal Employee's Health Benefits law preempts State and local laws in this area. While the Commission has adopted the views of its General

Counsel, the Commission has advised the committee as follows:

The Commission adopted the views of the general counsel that the Federal Employees Health Benefits Act preempts State laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time consuming and costly litigation with the States until its [*4] position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

COMMITTEE ACTION

H.R. 2931, as amended, guarantees that the provisions of health benefits contracts made under chapter 89, of title 5, United States Code, concerning benefits or coverage, would preempt any State and/or local insurance laws and regulations which are inconsistent with such contracts. Such a preemption, however, is purposely limited and will not provide insurance carriers under the program with exemptions from State laws and regulations governing other aspects of the insurance business such as the payment of premium taxes and requirements for statutory reserves.

H.R. 2931 is needed not only to clear up the doubt and confusion which exists among the carriers

and States, but also to clarify the Federal Government's and the Civil Service Commission's authority to regulate implementation of the law. As stated by the Civil Service Commission:

> While the FEHB law gives the Civil Service Commission the sole authority to negotiate contracts with participating carriers and to prescribe regulations to implement that law, the law does not give the Commission clear authority to issue regulations restricting the application of State laws when their provisions do not parallel the provisions in the Commission's health benefits contracts. The legislative history of the FEHB law is essentially silent on this point.

The committee also feels that a State's authority to control the licensing of health practitioners should also be preserved. As a result, an amendment was adopted which is designed to preserve certain States' authority by compelling insurance carriers to pay for any services which are contracted for if they are provided by a practitioner certified by the State to provide such services.

The amendment simply reserves to the States the right to determine who is and who is not qualified to provide health care; it encourages more innovative health techniques; it treats all health practitioners who treat the same conditions in an equitable manner: and it does not apply to mental health since existing Federal law already restricts payment to psychiatrists and clinical psychologists. (5 U.S.C., 8902(k))

A further modification to the bill allows employee organizations, as defined in section 8901(8) of title 5,

United States Code, to apply after December 31, 1978, and before January 1, 1980, to the Civil Service [*5] Commission for approval of a health benefit plan. Such organizations have been, in effect, barred from applying to the Commission for a health benefit plan unless they applied before January 1, 1964. This change, however, should not be considered as a reflection upon the merits of any new plan which may be applied for, as it merely allows the Civil Service Commission to review new proposals and to judge whether or not they meet the requirements necessary for Federal employee health benefits programs.

SECTION-BY-SECTION ANALYSIS

H.R. 2931, as amended, is an amendment to title 5, United States Code.

Section 1.—Amends section 8902 of Chapter 89, relating to contracts for Federal employee health benefits plans, by adding a new subsection (m) at the end thereof. The new subsection first provides that the provisions of any health benefit contract under chapter 89, shall supersede and preempt any State or local law, or any regulation issued under such law, relating to health insurance or plans, to the extent that such law or regulation is inconsistent with the provisions of the Federal employees' health benefits contract. The new subsection also provides for the treatment of any particular health condition other than a mental health condition, if such service is properly provided by a person licensed under State law to provide such service.

Section 2.—Amends section 8901(8) of title 5, United States Code, to permit an "employee organization." as defined under this section, to apply after

December 31, 1978, and before January 1, 1980, to the Civil Service Commission for approval of a health benefit plan.

ESTIMATED COST

Set forth below is a statement furnished by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
Washington, D.C., May 9, 1978.

Hon. ABRAHAM RIBICOFF,
Chairman, Committee on Governmental Affairs, Dirksen Senate Office Building, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed H.R. 2931, a bill to amend chapter 89 of title 5, United States Code, to establish a uniformity in Federal employee health benefits and coverage by preempting certain inconsistent State or local laws while recognizing the rights of States to determine who is to provide health services, as ordered reported by the Senate Committee on Governmental Affairs, May 9, 1978.

This bill requires that the provisions of contracts governing Federal health coverage and supersede State and local laws. Enactment of this bill could result in cost savings to the Government, through lower insurance premiums resulting from fewer contract ne-[*6]gotiations and from elimination of health in-

surance coverage required by some States but not by the Federal Government.

Should the committee so desire, we would be pleased to provide further details on this cost estimate.

Sincerely,

ROBERT A. LEVINE,
Deputy Director.

EVALUATION OF REGULATORY, PAPERWORK, AND PRIVACY IMPACT

Pursuant to rule 39 of the Standing Rules of the Senate, the committee anticipates that this legislation will have no adverse impact upon regulatory function, paperwork, or the privacy of any individual.

AGENCY COMMENTS

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET.
Washington, D.C., September 1, 1977.

Hon. ABRAHAM RIBICOFF,
Chairman, Committee on Governmental Affairs, U.S. Senate, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to the committee's request for the views of this office on H.R. 2931, to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and coverage provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage which are inconsistent with

such contracts as passed by the House of Representatives on June 20, 1977.

The purpose of this bill is to exempt the Federal employees health benefits (FEHB) program from State or local laws or regulations to the extent they conflict with the provisions of an FEHB contract in order to ensure that benefits and coverage under the program will be uniform.

In its report, the Civil Service Commission states a number of reasons for supporting enactment of this bill.

We concur in the views expressed by the Civil Service Commission and, accordingly, recommend enactment of H.R. 2931.

Sincerely,

JAMES M. FREY,
Assistant Director for Legislative Reference.

U.S. CIVIL SERVICE COMMISSION,
Washington D.C., August 26, 1977.

Hon. ABRAHAM A. RIBICOFF,
Chairman, Committee on Governmental Affairs,
U.S. Senate, Washington. D.C.

DEAR MR. CHAIRMAN: The Commission is voluntarily submitting a report on H.R. 2931, a bill to amend chapter 89 of title 5, United States Code, to establish uniformity in Federal employee health benefits and cover-[*7]age provided pursuant to contracts made under such chapter by preempting State or local laws pertaining to such benefits and coverage

which are inconsistent with such contracts. H.R. 2931 was passed by the House of Representatives on June 20, 1077.

H.R. 2931 would exempt the Federal employees health benefits program from any State or local law or regulation to the extent that such law or regulation conflicted with the provisions of the Federal Employees Health Benefits Act, regulations issued to contracts negotiated thereunder insofar as they pertain to benefits and coverage. It would not, as we read it, exempt the insurance carriers under the Federal employees health benefits programs from the payments of State premium taxes. State requirements for statutory reserves or other such regulations pertaining to the regulation of insurance within the State. It is a form of limited preemption.

The bill would statutorily establish uniformity of benefits and coverage under the Federal employees health benefits program as well as solve the other problems encountered in recent years in the administration of the program. The Commission strongly urges favorable consideration of the bill.

All States regulate the health insurance business in various and varying ways. During the early years of the Federal employees health benefits program, our plans and contracts were either in compliance with these laws and regulations or the States elected not to enforce laws that conflicted with our plans. Whatever the reason, State laws offered few if any problems for our program. Over the past several years, however, more and more States have legislated the kinds of benefits and medical practitioners that carriers doing business in these States must cover. These laws in effect presented serious problems from the standpoint of the uniformity of bene-

fits under the program. It also placed carriers in serious jeopardy of loss of their license in a State unless they were to approve payment for a benefit not provided under our contract but required by State law. The problem was complicated by the fact that if the Indemnity Benefit Plan carrier, Aetna, lost their license to provide health insurance in those States or in any State they would no longer be eligible as a carrier under the Federal employees health benefits law since the law (5 U.S.C. 8902(b)) requires them to be licensed in all 50 States and the District of Columbia. We would have no Government-wide Indemnity Benefit Plan. In addition to legislation and regulations applying to the kinds of benefits and medical practitioners that must be recognized, many States went further in requiring not only specific types of care but the extent of benefits, family members to be covered, the age limits for family members, extension of coverage, the format and the type of informational material that must be furnished, including in some instances the type of language to be used, extension of coverage and the type of conversion contracts that must be offered. The problem was further compounded by numerous State laws being made extraterritorial. The effect which these conflicting State laws had on our program was that if we were to continue or our carriers were to continue to be subject to State law the benefits provided to Federal employees could not be uniform throughout the Country and were largely determine on the basis of what State the employee either resided in or worked in. In terms of contracting with the carrier, it was reaching a point where unless we were to negotiate contracts that included all the requirements of the various State laws and applied them nationwide, we would continue to [*8] place our carriers in

a position where they would not be in compliance with some State law. In addition, many of the State laws were in conflict with one another. It appeared that under these circumstances the only solution to the problem would lie in negotiating contracts for Federal employees in each State and issuing separate brochures to meet individual State requirements.

Confronted with this situation the General Counsel of the Commission was asked to review the law and furnish a legal opinion on the question of the dominance over State and local laws of the Federal Employees Health Benefits Act. The General Counsel's conclusion was that "the supremacy clause creates an immunity from State interference of Federal operations. The principles underlying the need for national uniformity in the administration of Federal functions operate to supersede conflicts, arising from State laws and apply with equal regard to the Commission's administration of the Federal Employees Health Benefits Act. The McCarran-Ferguson Act by its terms and the interpretation of the courts in no way diminishes the supremacy of the Federal Employees Health Benefits Act over State laws. If the Commission is to have a free hand it needs to administer the Federal Employees Health Benefits Act, no other conclusion can be reached."

The Commission adopted the views of the General Counsel that the Federal Employees Health Benefits Act preempts State laws in this area. The Commission realizes that enforcement of this preemption policy will almost inevitably lead to time-consuming and costly litigation with the States until its position is finally upheld by the courts. We do not view this as necessary or desirable. H.R. 2931 while

it has more limited applicability does provide an immediate and permanent statutory solution to the problem of maintaining uniformity of benefits to all enrollees in the plan and enables the Commission, acting on behalf of the Government, to administer the Federal Employees Health Benefits Act in a reasonable and efficient manner. Furthermore, enactment of H.R. 2931 should result in a reduction in cost to the Federal Government and the employees.

For these reasons the Commission strongly urges enactment at an early date of H.R. 2931.

The Office of Management and Budget advises that from the standpoint of the administration's program there is no objection to the submission of this report.

By direction of the Commission:
Sincerely yours,

ALAN K. CAMPBELL,
Chairman.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., September 9, 1977.

B-164562.
Hon. ABRAHAM RIBICOFF,
Chairman, Committee on Governmental Affairs, U.S. Senate.

DEAR MR. CHAIRMAN: This is in response to your request for our comments on H.R. 2931, which provides that contracts between the [*9] Civil Service Commission and health plan carriers for the Federal employee health benefits program shall preempt

State and local laws which conflict with such contracts.

In our report, "Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers," MWD-76-49, dated October 17, 1975, we discussed a number of State health insurance laws, regulations, and Attorney General's opinions which were impacting on the coverage provided under Federal employee health plans. We concluded that because States were becoming more active in establishing and enforcing health insurance requirements which conflicted with the Civil Service Commission's contracts with Federal employees health plan carriers, such requirements could be expected to result in

> increased premium costs to both the Government and Federal employees, and
>
> a lack of uniformity of benefits for all enrollees in the same health plan, since enrollees in some States would be paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

We recommend to the Subcommittee on Retirement and Employment Benefits, House Committee on Post Office and Civil Service, that it consider legislation to clarify whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

H.R. 2931 is responsive to our recommendation and should help contain increasing Federal employee health plan premium costs, as well as provide uniformity and equity in benefit coverage. Accordingly, we favor passage of H.R. 2931.

Sincerely yours,

ROBERT F. KELLER,
Deputy Comptroller General of the United States.

CHANGES IN EXISTING LAW

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law L which no change is proposed is shown in roman; existing law proposed to be omitted is enclosed in black brackets; new matter is shown in italic):

TITLE 5, UNITED STATES CODE

* * * * * * *

Chapter 89—Health Insurance

* * * * * * *

Sec. 8902. Contracting authority

(a) * * *

* * * * * * *

(m) (1) The provisions of any contract under this chapter which *relate to the nature or extent of coverage or benefits (including pay-*[*10]*ments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.*

"(2) (A) Notwithstanding the provisions of paragraph (1), if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care

and treatment of any particular health condition other than a mental health condition, the carrier shall provide, pay, or reimburse for any such health service properly provided by a person licensed under State law to provide such service.

"(B) The provisions of this paragraph shall not apply to group practice prepayment plans.".

*SEC. 8901 * * **

(8) "employee organization" means an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, [before January 1, 1964] "after December 31, 1978, and before January 1, 1980" applied to the Commission for approval of a plan provided under section 8903(3) of this title.

[*1]

105TH CONGRESS *1st Session* | HOUSE OF REPRESENTATIVES | REPORT 105-374

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1997

NOVEMBER 4, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. BURTON of Indiana, from the Committee on Government Reform and Oversight, submitted the following

REPORT

[To accompany H.R. 1836]

[Including cost estimate of the Congressional Budget Office]

The Committee on Government Reform and Oversight, to whom was referred the bill (H.R. 1836) to amend chapter 89 of title 5, United States Code, to improve administration of sanctions against unfit health care providers under the Federal Employees Health Benefits Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

[*2] Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Employees Health Care Protection Act of 1997".

SEC. 2. DEBARMENT AND OTHER SANCTIONS.

(a) AMENDMENTS.—Section 8902a of title 5, United States Code, is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking "and" at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(iii) by adding at the end the following:

"(D) the term 'should know' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;"; and

(B) in paragraph (2)(A), by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)";

(2) in subsection (b)—

(A) by striking "The Office of Personnel Management may bar" and inserting "The Office of Personnel Management shall bar"; and

(B) by amending paragraph (5) to read as follows:

"(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).";

(3) by redesignating subsections (c) through (d) as subsections (d) through (j), respectively, and by inserting after subsection (b) the following:

"(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

"(1) Any provider—

"(A)whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

"(B)that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

"(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

"(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

"(4) Any provider that the Office determines, in connection with claims presented under this

chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

"(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.";

(4) in subsection (d) (as so redesignated by paragraph (3)) by amending paragraph (1) to read as follows: [*3]

"(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

"(A) an item or service not provided as claimed,

"(B) charges in violation of applicable charge limitations under section 8904(b), or

"(C) an item or service furnished during a period in which the provider was debarred

from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);";

(5) in subsection (f) (as so redesignated by paragraph (3)) by inserting after "under this section" the first place it appears the following: "(where such debarment is not mandatory)";

(6) in subsection (g) (as so redesignated by paragraph (3))—

(A) by striking "(g)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

"(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).";

(B) in paragraph (3)—

(i) by inserting "of debarment" after "notice"; and

(ii) by adding at the end the following: "In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).";

(C) in paragraph (4)(B)(i)(I) by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)"; and

(D) by striking paragraph (6);

(7) in subsection (h) (as so redesignated by paragraph (3)) by striking "(h)(1)" and all that follows through the end of paragraph (2) and inserting the following:

"(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

"(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion."; and

(8) in subsection (i) (as so redesignated by paragraph (3))—

(A) by striking "subsection (c)" and inserting "subsection (d)"; and [*4]

(B) by adding at the end the following: "The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or

later owing by the United States to the party against whom the penalty or assessment has been levied.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTIONS.—(A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under such paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments based on convictions occurring after the date of the enactment of this Act.

SEC. 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES.

(a) DEFINITION OF A CARRIER.—Paragraph (7) of section 8901 of title 5, United States Code, is amended by striking "organization;" and inserting "organi-

zation and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;".

(b) SERVICE BENEFIT PLAN.—Paragraph (1) of section 8903 of title 5, United States Code, is amended by striking "plan," and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States,".

(c) PREEMPTION.—Section 8902(m) of title 5, United States Code, is amended by striking "(m)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.".

SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR CERTAIN INDIVIDUALS.

(a) ENROLLMENT IN CHAPTER 89 PLAN.—For purposes of chapter 89 of title 5, United States Code, any period of enrollment—

(1) in a health benefits plan administered by the Federal Deposit Insurance Corporation before the termination of such plan on January 3, 1998, or

(2) subject to subsection (c), in a health benefits plan (not under chapter 89 of such title) with respect to which the eligibility of any employees or retired employees of the Board of Governors of the Federal Reserve System terminates on January 3, 1998,

shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

(b) CONTINUED COVERAGE.—(1) Subject to subsection (c), any individual who, on January 3, 1998, is enrolled in a health benefits plan described in subsection (a)(1) or (2) may enroll in an approved health benefits plan under chapter 89 of title 5, United States Code, either as an individual or for self and family, if, after taking into account the provisions of subsection (a), such individual—

(A) meets the requirements of such chapter for eligibility to become so enrolled as an employee, annuitant, or former spouse (within the meaning of such chapter); or

(B) would meet those requirements if, to the extent such requirements involve either retirement system under such title 5, such individual satisfies similar requirements or provisions of the Retirement Plan for Employees of the Federal Reserve System.

Any determination under subparagraph (B) shall be made under guidelines which the Office of Personnel Management shall establish in consultation with the Board of Governors of the Federal Reserve System.

(2) Subject to subsection (c), any individual who, on January 3, 1998, is entitled to continued coverage under a health benefits plan described in subsection (a)(1) or (2) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, but only for the same remaining period as would have been [*5] allowable under the health benefits plan in which such individual was enrolled on January 3, 1998, if—

(A) such individual had remained enrolled in such plan; and

(B) such plan did not terminate, or the eligibility of such individual with respect to such plan did not terminate, as described in subsection (a).

(3) Subject to subsection (c), any individual (other than an individual under paragraph (2)) who, on January 3, 1998, is covered under a health benefits plan described in subsection (a)(1) or (2) as an unmarried dependent child, but who does not then qualify for coverage under chapter 89 of title 5, United States Code, as a family member (within the meaning of such chapter) shall be deemed to be entitled to continued coverage under section 8905a of such title, to the same extent and in the same manner as if such individual had, on January 3, 1998, ceased to meet the requirements for being considered an unmarried dependent child of an enrollee under such chapter.

(4) Coverage under chapter 89 of title 5, United States Code, pursuant to an enrollment under this section shall become effective on January 4, 1998.

(c) ELIGIBILITY FOR FEHBP LIMITED TO INDIVIDUALS LOSING ELIGIBILITY UNDER FORMER HEALTH PLAN.—Nothing in subsection (a)(2) or any paragraph of subsection (b) (to the extent such paragraph relates to the plan described in subsection (a)(2)) shall be considered to apply with respect to any individual whose eligibility for coverage under such plan does not involuntarily terminate on January 3, 1998.

(d) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND.—The Federal Deposit Insurance Corporation and the Board of Governors of the Fed-

eral Reserve System shall transfer to the Employees Health Benefits Fund under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

(e) ADMINISTRATION AND REGULATIONS.—The Office of Personnel Management—

(1) shall administer the provisions of this section to provide for—

(A) a period of notice and open enrollment for individuals affected by this section; and

(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

(2) may prescribe regulations to implement this section.

SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.

The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person

for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP.

(a) AUTHORITY TO READMIT.—

(1) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8903a the following:

"§ 8903b. Authority to readmit an employee organization plan

"(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

"(b) A contract for a plan approved under this section shall require the carrier—

"(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

"(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.".

[*6] (2) CONFORMING AMENDMENT.—The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903a the following:

"8903b. Authority to readmit an employee organization plan.".

(3) APPLICABILITY.—

(A) IN GENERAL.—The amendments made by this subsection shall apply as of the date of enactment of this Act, including with respect to any plan which has been discontinued as of such date.

(B) TRANSITION RULE.—For purposes of applying section 8903b(a) of title 5, United States Code (as amended by this subsection) with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting "second contract year" for "third contract year".

(b) TREATMENT OF THE CONTINGENCY RESERVE OF A DISCONTINUED PLAN.—

(1) IN GENERAL.—Subsection (e) of section 8909 of title 5, United States Code, is amended by striking "(e)" and inserting "(e)(1)" and by adding at the end the following:

"(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

"(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied

in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.".

(2) TRANSITION RULE.—In the case of any amounts remaining as of the date of enactment of this Act in the contingency reserve of a discontinued plan, such amounts shall be disposed of in accordance with section 8909(e) of title 5, United States Code, as amended by this subsection, by—

(A) the deadline set forth in section 8909(e) of such title (as so amended); or

(B) if later, the end of the 6-month period beginning on such date of enactment.

SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE.

(a) IN GENERAL.—Paragraph (2) of section 5948(a) of title 5, United States Code, is amended by striking "$20,000" and inserting "$30,000".

(b) AUTHORITY TO MODIFY EXISTING AGREEMENTS.—

(1) IN GENERAL.—Any service agreement under section 5948 of title 5, United States Code, which is in effect on the date of enactment of this Act may, with respect to any period of service remaining in such agreement, be modified based on the amendment made by subsection (a).

(2) LIMITATION.—A modification taking effect under this subsection in any year shall not cause an allowance to be increased to a rate which, if applied throughout such year, would cause the limitation under section 5948(a)(2) of

such title (as amended by this section), or any other applicable limitation, to be exceeded.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be considered to authorize additional or supplemental appropriations for the fiscal year in which occurs the date of enactment of this Act.

SEC. 8. CLARIFICATION RELATING TO SECTION 8902(k).

Section 8902(k) of title 5, United States Code, is amended—

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following:

"(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.".

I. SUMMARY OF LEGISLATION

H.R. 1836, as amended by the Committee, amends several provisions in title 5, United States Code. It provides the Office of Personnel Management (OPM) additional tools to fight waste, fraud, and abuse in the Federal Employees Health Benefits (FEHB) program. With these tools, OPM will be able to deal swiftly with [*7] health care providers who try to defraud the FEHB program. OPM will be better equipped to bar health care providers who engage in misconduct from participating in the FEHB program or to impose monetary penalties on them. The bill

also provides that an association of organizations may underwrite health care plans in the FEHB program, and it broadens the current statutory language preempting State insurance laws.

In addition, the bill permits certain employees of the Federal Deposit Insurance Corporation (FDIC) and the Federal Reserve Board (Fed) to participate in the FEHB program, and it requires OPM to encourage carriers who contract with third parties to obtain discounts from health care providers to seek assurances that the conditions for the discounts are fully disclosed to such providers. It also establishes statutory requirements for readmitting health care plans sponsored by employee organizations that have previously discontinued participation in the FEHB program. Under current law, when a health care plan discontinues participation in the FEHB program, OPM must credit that plan's remaining contingency reserves to those plans that remained in the FEHB program in the contract year after the discontinuance. This bill requires OPM to complete the distribution by the end of the second contract year after the plan is discontinued.

The maximum amount of the physicians comparability allowance under 5 U.S.C. § 5948 is increased from $20,000 to $30,000.

The bill also amends 5 U.S.C. § 8902(k) to explicitly permit carriers to provide for direct access and direct payments to licensed health care providers who are not currently enumerated in the statute.

II. BACKGROUND AND NEED FOR THE LEGISLATION

SECTION 1

H.R. 1836 was introduced by Mr. Burton of Indiana to strengthen the integrity and standards of the FEHB program and allow it to maintain its reputation as a high quality and cost-effective program. The FEHB program is the largest employer-sponsored health insurance system in the country. In 1997, the $16 billion FEHB program will insure more than nine million Federal employees, retirees, and their dependents. Partial portability, the absence of preexisting condition limitations, and an annual open enrollment period are facets of the FEHB program that make it an extremely attractive health care system. The program's market orientation has effectively contained costs through private sector competition with limited governmental intervention. The program is often cited as a model of efficiency and effectiveness that the private sector and the public sector should attempt to replicate. This bill will improve the program and its performance without changing the market principles that are the key to its success.

SECTION 2

Section 2 of this bill addresses the debarment of health care providers engaging in fraudulent practices. This provision would strengthen the ability of OPM to bar health care providers who engage in professional and or financial misconduct from participating [*8] in the FEHB program or to impose monetary penalties on them. Under this bill, the administrative sanctions authority would conform more closely with provisions of Medicare law. The paral-

lels between these provisions and Medicare law should benefit not only OPM, but also carriers and health care providers, who are already familiar with interpretations and practices under similar Medicare provisions.

In addition, this bill streamlines the debarment process by generally permitting OPM to debar a provider before a hearing is held. However, upon request, the provider would be entitled to an administrative hearing after an adverse de-termination is made if the provider shows that due process rights were not previously afforded with respect to any finding of fact which is relied upon as a cause for the adverse de-termination. The hearing will be held before a hearing officer who shall be designated by the Director of OPM and conducted without regard to the requirements of subchapter II of chapter 5 and chapter 7 of title 5, United States Code. Judicial review shall lie with the United States District Court for the District of Columbia or other appropriate district, rather than, as under current law, with the United States Court of Appeals for the Federal Circuit.

Under current law, OPM is permitted to debar health care providers on certain grounds, but it is not required to do so. This bill makes debarment mandatory if a health care provider is convicted of certain criminal offenses or is currently debarred, suspended or otherwise excluded from any procurement or nonprocurement activity within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994.

OPM retains its existing authority to debar health care providers on grounds relating to professional licensing, and this bill adds four additional grounds for permissive debarment, including the determina-

tion that a provider has charged substantially more than the provider's customary charge for health care services or supplies without good cause, or has charged for substandard or medically unnecessary health care services or supplies. The determination that a service or supply is medically unnecessary must be made by trained reviewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. These trained reviewers may be employees of OPM, other appropriately trained Federal employees, or contractors.

Existing law does not mandate a minimum period of debarment. This bill, however, requires that providers convicted under Federal or State law of certain offense must be de-barred for at least 3 years.

Under current law, OPM, in consultation with the Attorney General, may impose a civil monetary penalty of up to $10,000 on a health care provider guilty of certain misconduct. This bill modifies the grounds upon which OPM may assess such penalties. OPM's authority to impose a monetary penalty on health care providers for excessive charges or charges for substandard or medically unnecessary services or supplies is deleted. (That misconduct becomes, instead, grounds for permissive debarment.) But it is given [*9] additional authority to impose a civil penalty for charges exceeding Medicare limitations in violation of 5 U.S.C. §8904(b) or charging for items or services provided during a period of debarment.

These modifications of OPM's authority to debar health care providers and impose monetary penalties upon them will strengthen OPM's ability to protect the FEHB program—and the employees and retirees

who depend upon it—from fraudulent or abusive practices that drive up health care costs and premiums.

SECTION 3

The bill amends the definition of "carrier" and the description of the government-wide Service Benefit Plan under current law. The revised definition makes clear that an association of organizations, or other entities, may be the carrier for any health benefits plan in the FEHB program. The new description makes clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. Indeed, although the government-wide Service Benefit Plan historically has been underwritten by all of the affiliates of the sponsoring association, the withdrawal of an affiliate in a State would not affect the sponsoring association's ability to continue offering the plan in that State.

In addition, this bill broadens the preemption provisions in current law to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live. This change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts. It will also prevent carriers' cost-cutting initiatives from being frustrated by State laws. For example, a carrier's effort to establish a preferred provider organization (PPO) across the country would not be jeopardized by State-mandated "any willing provider" statutes.

SECTION 4

Another important component of this bill provides consistent health benefit coverage for individuals

who were covered by health care plans offered by the Board of Governors of the Federal Reserve System (Fed) or the Federal Deposit Insurance Corporation (FDIC). A number of years ago, the Fed decided to drop out of the FEHB program and sponsor a separate health care plan for its employees. But in 1993, the Fed elected to abandon this health care experiment and offer its employees only FEHB program coverage. The Fed per-mitted some retirees and employees to participate in a health care plan offered by one of the Federal Reserve Banks because current law generally requires five years of continuous enrollment in the FEHB program before individuals may participate in it after retirement. Consequently, some current employees approaching retirement age and a number of individuals who retired while the Fed had its own system are not eligible to participate in the FEHB program during retirement. The FDIC faces a similar situation because it plans to eliminate its alternative health insurance plan at the end of 1997. Without this legislation, the FDIC and the Fed will have to establish a non-FEHB program plan for those employees who are ineligible for coverage. This would be administratively burdensome and costly to these Federal agencies [*10] and, ultimately, to the taxpayers. Under this proposal, these ineligible employees would be offered FEHB program coverage at no additional cost to the Government.

SECTION 5

The Committee has received complaints from numerous providers doing business with health plans in the Federal Employees Health Benefits (FEHB) program about dubious, and possibly unethical, practices in which discounts are taken without contractual rights or on a basis other than negotiated or

agreed to by contract. The genesis of these complaints to the Committee coincide with the insertion of language in the Office of Personnel Management's (OPM) annual FEHB call letter which appears to have had the effect of increasing these dubious practices in the FEHB program.

Organizations that take advantage of health care providers by arranging for a carrier to obtain access to discounted rates they are not entitled to are the focus of Section 5 of H.R. 1836. The first victims of this practice are the doctors and hospitals. But in the end, all of us pay the price as the losses incurred by these providers are shifted to other consumers of medical services. Eventually this cost shifting will lead to higher prices for medical services, higher insurance premiums, or a decline in the quality of services available.

The Committee's sole interest is in ensuring that the integrity of the FEHB program is maintained and that the imprimatur of the United States Government is not used in any way to encourage or condone an unethical health care practice within the FEHB program. The Committee strongly believes that the full disclosure of discounted rate agreements is necessary to protect not just health care providers, but more importantly, the very integrity of the FEHB program. The Committee does not intend to interject the Government into the contracting arrangements between private sector health care providers, vendors and health plans; nor is it the role of the Government to ensure that either party negotiates a con-tract to its advantage. The Committee, however, does expect OPM to be aware of dubious practices in the health care industry and to be cogni-

zant of the influence of its directives to FEHB plans on those practices.

The language included in Section 5 of the bill as introduced, was modified during the mark up of the bill held on October 22, 1997 by the Subcommittee on Civil Service. As a result of further bipartisan discussion with the Office of Personnel Management, alternative language was drafted by OPM and was inserted into Section 5 during the full Committee Business Meeting held on October 31, 1997. The language provided to the Committee by OPM was adopted verbatim.

As a result of this action by the Congress, OPM is expected to clarify the instructions in its annual call letter to ensure that FEHB carriers understand that in obtaining provider discounts, the standard to be observed is not only one of cost-effectiveness, but ethical practices as well. Further, the Committee expects the Office of Personnel Management to respond appropriately to specific and credible complaints concerning discounts taken without disclosure of the conditions for such discounts. Finally, the Committee expects the Office of Personnel Management to be mindful [*11] of its own Federal Employees Health Benefits Acquisition Regulation (FEHBAR) promulgated at 48 Code of Federal Regulations 1609.7001 (b)(2) requiring legal and ethical business and health care practices in the performance of FEHB contracts.

SECTION 6

This bill also establishes rules under which a health care plan sponsored by an employee organization may reenter the FEHB program after previously discontinuing its participation. Under current law, such plans may not reenter. The bill will permit

such a plan to again participate in the FEHB program after the end of the third contract year following its discontinuance (2 contract years in the case of plans applying for a contract year beginning before January 1, 2000). This waiting period is necessary to discourage plans from leaving the FEHB program in order to eliminate their high risk policyholders and then quickly begin again with a clean slate. Such plans must also be underwritten by a subcontractor li-censed to issue group health insurance in all the States and the District of Columbia and demonstrate experience in service delivery within a managed care system.

In addition, this bill requires OPM to distribute the contingency reserves of certain discontinued plans within 2 contract years. Under current law, OPM is required to distribute those reserves to plans continuing in the FEHB program in the contract year after the discontinuance. OPM has interpreted the current statutory language to provide it with unlimited time in which to complete this distribution. The Committee believes, however, that OPM should be required to completely distribute these reserves in 2 years in order to offset the additional liabilities assumed by continuing plans.

SECTION 7

The bill also increases the maximum physicians comparability allowance Federal agencies may pay from $20,000 to $30,000 per year. In 1978, Congress enacted the Physicians Comparability Act of 1978 (PCA), which provides for such annual allowances, in response to a critical shortage of Federal physicians and income disparities between physicians employed by the Departments of Defense and Veterans Affairs and other Federal doctors. That Act has been reau-

thorized several times, most recently in H.R. 2541, the Fiscal Year 1998 Treasury, Postal, and General Government Services Appropriations Act. But the maximum allowance has not been increased since 1987, and the gap between special pay provisions for VA physicians and Federal doctors covered by the PCA has widened in the last four years. Federal physicians also earn considerably less than private sector doctors. But Federal physicians conduct research on AIDS, cancer, and heart disease; they protect the safety of food and drugs; and they perform many other valuable functions. The Committee believes the maximum allowance should be increased to ensure the Federal Government can recruit and retain highly-trained and well-qualified physicians to perform these important functions.

[*12] SECTION 8

Under current law, carriers offering health benefit plans under the FEHB program are required to provide for direct access and direct payments to certain enumerated health care providers. In recent years, some providers have argued that providers who are not specifically enumerated are placed at a competitive disadvantage in gaining access to the FEHB program market place. Nothing in the statute currently prevents carriers from voluntarily providing direct access or payments to other health care providers. Nevertheless, the Committee has been advised that on occasion this provision has been misconstrued to prohibit such arrangements. The bill will prevent such misreading of the statute in the future by explicitly permitting FEHB program carriers to provide direct access and direct payment to licensed health care providers who are not specifically identified in the statute.

III. Legislative Hearings and Committee Actions

H.R. 1836 was introduced on June 10, 1997 by the Honorable Dan Burton. The bill was referred to the Committee on Government Reform and Oversight on June 10, 1997, and it was referred to the Subcommittee on Civil Service on June 11, 1997. The subcommittee held a mark up on October 22, 1997. Representative Mica offered an amendment in the nature of a substitute. Representative Sessions offered an amendment to the amendment in the nature of a substitute, and Representative Morella offered two. The amendment offered by Representative Sessions and one of the amendments offered by Representative Morella, as well as the amendment in the nature of a substitute were adopted by voice votes. (The other amendment offered by Representative Morella was withdrawn.) The subcommittee favorably reported the bill, as amended, to the full Committee by a voice vote.

On October 31, 1997, the Committee on Government Reform and Oversight met to consider the bill as amended by the subcommittee. Chairman Burton offered an amendment in the nature of a substitute. The amendment in the nature of a substitute was adopted by voice vote. The Committee favorably reported the bill, as amended, to the full House by voice vote.

IV. Committee Hearings and Written Testimony

The Committee held no hearings and received no written testimony. However, the Subcommittee on Civil Service did examine the debarment provisions of H.R. 1836 and the issue of "silent PPOs" at an oversight hearing, "FEHB Rate Hikes—What's Behind Them?," on October 8, 1997. William E. Flynn,

III, OPM's Associate Director, Retirement and Insurance Service, testified that OPM supported the improved debarment procedures contained in this bill. Stephen W. Gammarino, Vice President, Federal Employee Programs, Blue Cross-Blue Shield Association, testified that the Blue Cross-Blue Shield Association does not support or use "silent PPOs" and does not believe their use should be required or mandated. He cautioned, however, against overregulation of rate agreements between carriers, networks, and health care providers as a method of controlling costs. The private sector, he testified, is much [*13] more innovative than government and can move much more quickly to control costs without government intervention.

V. Explanation of the Bill as Reported: Section-by-Section Analysis

Sec. 1. The short title of the bill is the Federal Employees Health Care Protection Act of 1997.

Sec. 2. This section amends 5 U.S.C. § 8902a regarding the Office of Personnel Management's (OPM) authority to debar or otherwise sanction health care providers in the Federal Employees Health Benefits Program (FEHBP).

Subsection (a)(1) adds a new paragraph to define the term "should know". Under this definition, the term means that a person acted in deliberate ignorance or with reckless disregard of the truth or falsity of information, and no proof of specific intent to defraud is required. This is the same definition given the term under Medicare law in 42 U.S.C. § 1320a–7a(7).

Subsections (a)(2)–(3) provide OPM with both permissive and mandatory authority to debar health

care providers. Under current law, OPM has only permissive authority to debar such providers for certain reasons.

Subsection (a)(2) requires OPM to debar health care providers under the following circumstances:

1. Conviction, under Federal or State law, relating to fraud, corruption, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care service or supply;

2. Conviction, under Federal or State law, relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

3. Conviction, under Federal or State law, in connection with the interference with or obstruction of a Federal or State investigation or prosecution of a criminal offense described in (1) or (2) above;

4. Conviction, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; and

5. Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or non-procurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1944).

Subsection (a)(3) permits OPM to debar:

1. Any provider whose license has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, profes-

sional performance, or financial integrity, or who surrendered his license while a formal disciplinary proceeding relating to one of these subjects was pending;

2. Any provider that is an entity owned, directly or indirectly, by an individual who is convicted of any offense that is a ground for mandatory debarment, against whom a civil monetary penalty has been assessed, or who has been debarred from participating in FEHB program, or in which such an individual holds a control interest of 5% or more; [*14]

3. Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action on which the sanction was based;

4. Any provider that OPM determines has charged substantially more than the provider's customary charge for health care services or supplies (unless OPM finds there is good cause for such charge), or has charged for substandard or medically unnecessary health care services or supplies; or

5. Any provider that OPM determines has committed acts for which a civil penalty may be imposed.

A determination under clause (4) above that a service or supply is medically unnecessary must be made by trained re-viewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. This requirement recognizes that the determination of whether services or sup-

plies are not medically necessary is a medical judgment. Accordingly, that judgment must be made by individuals trained in reviewing such medical questions and on the basis of protocols developed by physicians, not by bureaucrats. This requirement will not impose an undue burden on OPM. OPM may use appropriately trained employees of its own to review these matters, or they may take advantage of the broad expertise of the many trained medical personnel, including doctors, in the Federal workforce. OPM may also choose to contract with private organizations to perform some or all of these tasks.

Subsection (a)(4) modifies OPM's authority to impose a monetary civil penalty. Under current law, OPM can impose a penalty for several reasons, including OPM's determination that in connection with "a claim", a health care provider has (1) charged for services or supplies that the provider knows or should have known were not provided as claimed, or (2) charged substantially more than his customary charges or for substandard or medically unnecessary services or supplies. This subsection removes OPM's authority to impose a penalty based upon overcharges or substandard or medically un-necessary services or supplies. Instead, OPM is authorized to impose penalties based upon charges the provider knows or should have known exceeds Medicare limitations, as made applicable by 5 U.S.C. 8904(b), or were for an item or service furnished during a period when the provider was de-barred from participation in FEHB program, other than services permitted under subsection (g)(2)(B) (as redesignated by this bill). In addition, the word "claims" is substituted for the words "a claim."

Subsection (a)(5) revises current law to provide that OPM is not required to consider certain statutory criteria relating to the appropriateness of debarment when debarment is mandatory.

Subsection (a)(6) amends current law with respect to the effective date of debarment, the period of debarment, and the termination of debarment. With one exception, this subsection provides that mandatory or permissive debarment is effective at such time and upon reasonable notice to the provider, carriers, and covered individuals, as OPM shall specify in regulations. A debarred provider may request a hearing after debarment. Unless OPM determines that the health or safety of patients warrants an earlier effective [*15] date, OPM cannot make a determination adverse to a provider under its permissive debarment authority for acts for which a civil penalty may be imposed or under its authority to impose a civil penalty for acts for which such a penalty may be imposed until the provider has been given reasonable notice and an opportunity for the determination to be made after a hearing to be held before adverse action is taken. This subsection also establishes a minimum debarment period of 3 years for certain criminal convictions. Finally, this subsection also amends current law to permit OPM to terminate mandatory debarment after the minimum debarment period if it determines that there is no basis under mandatory debarment authority for continuing debarment.

Subsection (a)(7) amends provisions relating to the notice and hearing requirements and to judicial review. Under current law, OPM may not debar a provider or impose a monetary penalty until after the provider has been given written notice and an opportunity for a hearing on the record, and any person

affected by OPM's final adverse decision may obtain review in the United States Court of Appeals for the Federal Circuit. This subsection provides that a provider subject to an adverse determination by OPM is entitled to reasonable notice and an opportunity to request a hearing of record. OPM is required to grant a request for a hearing upon a showing that due process rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination. The hearing is not subject to sub-chapter II of chapter 5 or chapter 7 of title 5, which relate to administrative procedures and judicial review. Judicial review is available in the United States District Court for the District of Columbia, or for the district in which the plaintiff resides or has his or her principal place of business. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record, taken as a whole, to support the findings by OPM or unless OPM has abused its discretion.

Subsection (a)(8) amends current law regarding the collection of civil monetary penalties or assessments. Under this subsection, the amount of a penalty or assessment may be withheld from any sum then or later owed to the provider by the United States.

Subsection (b) establishes effective dates for the amendments made by this section. With three exceptions, these amendments take effect upon enactment. However, paragraphs (2), (3), and (5) of section 8902a(c), as amended by subsection (a)(3) of this Act, apply only to misconduct occurring after the date of enactment. Similarly, 5 U.S.C. 8902a(d)(1)(B), as amended by section (a)(4) of this Act, applies only with respect to charges for items or

services furnished after the date of enactment, and section 8902a(g)(3), as amended by subsection (a)(6)(B) of this Act, shall apply only to debarments based upon convictions occurring after the date of the enactment of this Act.

SEC. 3. Subsection (a) of this section amends 5 U.S.C. 8901(7) to make clear that an association of organizations, or other entities, may sponsor a health benefits plan, including the government-wide Service Benefit Plan and that the sponsor is the carrier. The Service Benefit Plan has been historically, and is currently, sponsored by an association whose members are lawfully engaged in provid-[*16]ing, paying for, or reimbursing the cost of group health plan functions. This revision conforms the statutory language to more clearly reflect this historical preference.

Subsection (b) amends section 8903 to make clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. The carrier for this plan allocates its rights and obligations under the FEHB program contract among its affiliates which elect to participate. This revision makes clear that the withdrawal of an affiliate in a state would not affect the ability of the sponsoring association to continue offering the plan in that State.

Subsection (c) amends section 8902(m) to broaden the preemption of State and local laws with respect to health care contracts under the FEHB program. This amendment confirms the intent of Congress (1) that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) complete-

ly displace State or local law relating to health insurance or plans and (2) that this preemption authority applies to FEHB program plan contract terms which relate to the provision of benefits or coverage, including managed care programs.

SEC. 4. This section permits certain individuals who have participated in health care plans established by the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System to participate in the FEHB program.

SEC. 5. This section requires OPM to encourage carriers who contract with third parties for discounted rates from health care providers to seek assurances that the conditions for those discounts have been fully disclosed to the health care providers.

SEC. 6. This section establishes rules under which employee-sponsored health plans that have discontinued participation in the FEHB program may be readmitted, and it compels OPM to distribute the contingency reserves of certain discontinued plans within 2 contract years. Under this subsection, a previously discontinued employee-sponsored plan may be allowed to participate in the FEHB program after the end of the third contract year following its discontinuance (2 contract years in the case of plans applying for a contract year beginning before January 1, 2000). Such plans must be underwritten by a subcontractor licensed to issue group health insurance in all the States and the District of Columbia and demonstrate experience in service delivery within a managed care system.

SEC. 7. This section increases the maximum physicians comparability payment under 5 U.S.C. § 5948 from $20,000 to $30,000.

SEC. 8. This section amends 5 U.S.C. § 8902(k) to make clear that carriers may voluntarily agree to provide direct access and direct payments to licensed health care providers even though such arrangements are not required by law.

VI. COMPLIANCE WITH RULE XI

Pursuant to rule XI, clause 2(l)(3)(A), of the Rules of the House of Representatives, under the authority of rule X, clause 2(b)(1) and clause 3(f), the results and findings for those oversight activities [*17] are incorporated in the recommendations found in the bill and in this report.

VII. BUDGET ANALYSIS AND PROJECTIONS

H.R. 1836, as amended, provides for no new authorization, budget authority, or tax expenditures. Consequently, the provisions of section 308(a) of the Congressional Budget Act are not applicable.

VIII. COST ESTIMATE OF THE CONGRESSIONAL BUDGET OFFICE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 3, 1997.

Hon. DAN BURTON,
Chairman, Committee on Government Reform and Over-sight, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1836, the Federal Employees Health Care Protection Act of 1997, as ordered reported by the House Committee on Government Reform and Oversight on October 31, 1997.

If you wish further details on these estimates, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

H.R. 1836—Federal Employees Health Care Protection Act of 1997

Summary: H.R. 1836 would modify the administration of Federal Employees Health Benefits (FEHB) and raise the pay of certain physicians employed by the federal government. CBO estimates that enacting this bill would increase federal outlays by $2 million in 1998 and by between $30 million and $35 million over the 1998–2002 period, assuming appropriation of the authorized amounts. Because the bill would not affect direct spending or receipts, pay-as-you-go procedures would not apply.

Section 2 would strengthen the Office of Personnel Management's (OPM's) ability to bar or sanction unethical health providers. Section 3 makes technical changes regarding national plans, and it would expand a preemption of state and local authority to regulate health care plans that provide coverage under FEHB. This preemption would represent a mandate under the Unfunded Mandates Reform Act of 1995, but CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

Section 4 would allow retired employees of the Federal Deposit Insurance Corporation and the Federal Reserve Board access to FEHB plans. Section 5 would require OPM to encourage carriers who contract with third parties to obtain discounted rates

from health care providers to seek assurances that the conditions for those discounts have been fully dis-closed to the health care providers.

Section 6 clarifies FEHB procedures for the closure and readmittance of plans. Section 8 states that plans are allowed to provide [*18] direct access and payments to licensed health care providers, even when such arrangements are not required by law.

Section 7 would permit agencies to increase the maximum annual allowance payable to certain federal physicians from $20,000 to $30,000. CBO estimates that federal salary costs would increase by between $30 million and $35 million over the fiscal year 1998– 2002 period, subject to the availability of funds.

Estimated cost to the Federal Government: CBO estimates that enactment of H.R. 1836 would not affect federal outlays for FEHB, but would increase federal salary costs, subject to the availability of funds. For purposes of the estimate, CBO assumes that the bill will be enacted by the middle of fiscal year 1998 and that agencies would modify service agreements with physicians by year's end. The estimated costs of this legislation would affect several budget functions.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002
SPENDING SUBJECT TO APPROPRIATION					
Spending on physicians comparability allowance under current law:					
Budget authority	27	27	27	27	14
Estimated outlays	27	27	27	27	14
Proposed changes:					
Estimated authorization level	2	9	9	9	5
Estimated outlays	2	9	9	9	5
Spending on physicians comparability allowance under H.R. 1836:					
Estimated authorization level	29	36	36	36	36
Estimated outlays	29	36	36	36	19

Basis of estimate

Spending for Federal employees health benefits

CBO estimates that H.R. 1836 would not significantly affect FEHB spending. The debarment and sanction provisions in Section 2 and the clarification

of federal preemption of state insurance laws in Section 3 could possibly reduce FEHB costs.

Section 5 could discourage some FEHB plans from using certain discount vendors, potentially increasing costs. Based on a survey conducted by the Office of Personnel Management, however, FEHB plans believe that their discount vendors provide disclosure of the conditions of the discounts to health providers.

Section 4 would allow OPM to determine payments from the Federal Deposit Insurance Corporation and the Federal Reserve Board to the FEHB fund such that giving enrollees in plans sponsored by those agencies access to FEHB plans would not affect federal spending.

Section 8 allows plans to make direct payments to certain non-physician providers. Because plans already have such authority, the enactment of that section would not change spending.

Physicians comparability allowance

Current law authorizes certain agencies to pay allowances of up to $20,000 a year to recruit and retain physicians for certain positions, such as those with long vacancies or high turnover rates. To receive the allowance, physicians must agree to work at least one year at the agency. CBO estimates that increasing the maximum [*19] annual allowance from $20,000 to $30,000 would increase salary costs by between $30 million and $35 million over the 1998–2002 period. This estimate is based on information provided by OPM, including data on the number of federal physicians receiving comparability allowances and the average annual premium that they receive under current service agreements. CBO estimates that the provision would increase the average

allowance for 1,800 physicians by about $5,000 a year.

The authority for agencies to offer allowances to physicians was recently extended through fiscal year 2000 by the Treasury and General Government appropriations bill for fiscal year 1998 (P.L. 105-61). Under that authority, agencies and physicians can enter into contracts that extend through the end of fiscal year 2002. Most service agreements are made for two years. CBO assumes that the number of outstanding contracts in fiscal year 2001 will approximate the number of contracts in 2000, and the number of contracts in fiscal year 2002 will be about one-half of the number estimated for 2001. Thus, the increase in costs for fiscal year 2002 is lower than for previous years.

Pay-as-you-go considerations: None.

Intergovernmental and private sector mandates: H.R. 1836 would expand the preemption of state and local authority to regulate health care plans that provide coverage under FEHB. Current law prohibits state and local governments from regulating the nature and extent of coverage and benefits for people covered by FEHB if the regulation or law is inconsistent with the contract provisions. The new language would preclude state and local governments from regulating the provision of coverage or benefits as well, and it removes the language dealing with inconsistencies, thereby giving the federal contract provisions clear authority. These changes would affect states that have comparably higher requirements for types of medical coverage offered by health plans. Although this preemption would be considered a mandate under UMRA, CBO estimates that

any costs to state or local governments arising from this mandate would be minimal.

Estimate prepared by: Federal Cost Estimate: Jeff Lemieux, FEHB; John R. Righter, federal pay. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on Private Sector: Sandra Christensen.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

IX. Specific Constitutional Authority for This Legislation

Pursuant to rule XI, clause 2(l)(4), the Committee finds that clauses 14 and 18 of Article 1, Section 8 of the U.S. Constitution grants Congress the power to enact this law.

X. Committee Recommendation

On October 31, 1997, a quorum being present, the Committee ordered the bill, as amended, favorably reported to the House for consideration.

[*20] Committee on Government Reform and Oversight—105th Congress Rollcall

Date: October 31, 1997.

Amendment No. 1.

Description: Amendment in the nature of a substitute.

Offered by: Mr. Dan Burton (IN).

Adopted by voice vote.

Final passage of H.R. 1836, as amended.

Offered by: Hon. Dan Burton (IN).

Adopted by voice vote.

XI. Congressional Accountability Act; Public Law 104-1; Section 102(B)(3)

The amendments made by H.R. 1836 will apply to employees and former employees of the legislative branch who participate in the Federal Employees Health Benefits Program to the same extent as it applies to other participating employees.

XII. Unfunded Mandates Reform Act; Public Law 104-4; Section 423

H.R. 1836, as amended, does not impose any Federal mandates on State, local, and tribal governments, or the private sector. Section 3(c) of the bill preempts any State and local law, and any regulations issued thereunder, that relates to health insurance or plans. The effect of these provisions is to permit health care plans participating in the FEHB program to offer uniform benefits nationwide because all questions relating to the nature, provision, or extent of coverage or benefits are to be determined by the terms of the contract between the carrier and OPM.

XIII. Federal Advisory Committee Act (5 U.S.C. App.) Section 5(b)

The Committee finds that the legislation does not establish or authorize establishment of an advisory committee within the definition of 5 U.S.C. App., Section 5(b).

XIV. Changes in Existing Law

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in

italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

* * * * * * *

CHAPTER 59—ALLOWANCES

* * * * * * *

SUBCHAPTER IV—MISCELLANEOUS ALLOWANCES

* * * * * * *

[*21]

§ 5948. Physicians comparability allowances

(a) Notwithstanding any other provision of law, and in order to recruit and retain highly qualified Government physicians, the head of an agency, subject to the provisions of this section, section 5307, and such regulations as the President or his designee may prescribe, may enter into a service agreement with a Government physician which provides for such physician to complete a specified period of service in such agency in return for an allowance for the duration of such agreement in an amount to be determined by the agency head and specified in the agreement, but not to exceed—

(1) * * *

(2) [$20,000] *$30,000* per annum if the Government physician has served as a Government physician for more than twenty-four months.

For the purpose of determining length of service as a Government physician, service as a physician under section 4104 or 4114 of title 38 or active service as a medical officer in the commissioned corps of the Pub-

lic Health Service under Title II of the Public Health Service Act (42 U.S.C. ch. 6A) shall be deemed service as a Government physician.

* * * * * * *

CHAPTER 89—HEALTH INSURANCE

* * * * * * *

Sec.
8901. Definitions.

* * * * * * *

8903b. Authority to readmit an employee organization plan.

* * * * * * *

§ 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) * * *

* * * * * * *

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee [organization;] *organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;*

§ 8902. Contracting authority

(a) * * *

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical **[*22]** psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

[(2)] *(3)* The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

* * * * * * *

[(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of cover-

age or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.]

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * *

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term "provider of health care services or supplies" or "provider" means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term "individual covered under this chapter" or "covered individual" means an employee, annuitant, family member, or former spouse covered by a health benefits plan described by section 8903 or 8903a; [and]

(C) an individual or entity shall be considered to have been "convicted" of a criminal offense if—

(i) * * *

* * * * * * *

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which [*23] a judgment

of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity[.]; and

(D) the term "should know" means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under [subsection (b) or (c)] subsection (b), (c), or (d), a provider is barred from participating in the program under this chapter, no payment may be made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

* * * * * * *

(b) [The Office of Personnel Management may bar] *The Office of Personnel Management shall bar* the following providers of health care services or supplies from participating in the program under this chapter:

(1) * * *

* * * * * * *

[(5) Any provider—

[(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the

provider's professional competence professional performance, or financial integrity; or

[(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.]

(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).

(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

(1) Any provider—

(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in sub-

[*24] *section (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.*

(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.

[(c)] (d) Whenever the Office determines—

[(1) in connection with a claim presented under this chapter, that a provider of health care services or supplies—

[(A)has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

[(B)has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies;]

(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

(A) an item or service not provided as claimed,

(B) charges in violation of applicable charge limitations under section 8904(b), or

(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);

* * * * * * *

[(d)] (e) The Office— [*25]

(1) * * *

* * * * * * *

[(e)] (f) In making a determination relating to the appropriateness of imposing or the period of any debarment under this section (*where such debarment is not mandatory*), or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account—

(1) * * *

* * * * * * *

[(f)(1) The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.]

(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).

* * * * * * *

(3) Any notice of debarment referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of

time for which such debarment is to remain effective. *In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).*

(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such manner as the Office may by regulation prescribe, for termination of the debarment.

(B) The Office may—

(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period, if the Office determines, based on the conduct of the applicant, that—

(I) there is no basis under [subsection (b) or (c)] *subsection (b), (c), or (d)* for continuing the debarment; and

[(6) The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.] **[*26]**

[(g)(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to

cross-examine witnesses against the provider in any such hearing.

[(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.]

(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place

of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

[(h)] *(i)* A civil action to recover civil monetary penalties or assessments under subsection [(c)] *(d)* shall be brought by the Attor-[*27]ney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees Health Benefits Fund. *The amount of a penalty or assessment as finally de-*

termined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.

[(i)] *(j)* The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, *which may be underwritten by participating affiliates licensed in any number of States*, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member,

former spouse, or person having continued coverage under section 8905a of this title.

* * * * * * *

§8903b. Authority to readmit an employee organization plan

(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

(b) A contract for a plan approved under this section shall require the carrier—

(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and **[28]**

(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.

§ 8909. Employees Health Benefits Fund

(a) * * *

* * * * * * *

(e)(1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term fol-

lowing that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

* * * * * * *

[*1]

105TH CONGRESS 2d Session

SENATE

REPORT 105-257

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1998

JULY 21, 1998.—Ordered to be printed

Mr. THOMPSON, from the Committee on Governmental Affairs, submitted the following

REPORT

[To accompany H.R. 1836]

The Committee on Governmental Affairs, to which was referred the bill (H.R. 1836) to strength the integrity and standards of the Federal Employee Health Benefits Program (FEHBP) and allow it to maintain its reputation as a high quality and cost-effective program, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends, by a vote of 9–0, that the bill as amended do pass.

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I. Summary and Purpose

H.R. 1836, the Federal Employee Health Care Protection Act of 1998, was designed to make a number of improvements to the Federal Employee Health Benefits Program (FEHBP). Specifically, the bill would allow the government to impose sanctions on the providers or bar them from selling coverage to any government agency; would encourage full disclosure in discounted rate agreements; and would establish standards for readmitting discontinued health [*2] plans and for crediting of associated contingency reserves. Additionally, the bill would make a number of technical changes.

II. Legislative History

H.R. 1836 was introduced by Representative Dan Burton (R–IN) on June 10, 1997. The bill was referred to the House Government Reform and Oversight Committee on June 10, 1997 and to the Subcommittee on Civil Service on June 11, 1997. The legislation was marked up, with amendments, by the Subcommittee on October 22, 1997, and by the full Committee on October 31, 1997. No hearings were held, nor written testimony received. The House passed H.R. 1836 by voice vote, under suspension of the rules, on November 4, 1997.

On November 5, 1997, H.R. 1836 was referred to the Senate Committee on Governmental Affairs, and to the Subcommittee on International Security, Proliferation, and Federal Services on November 11, 1997. On March 31, 1998, a majority (8) of the Subcommittee Members approved reporting favorably

H.R. 1836 to the full Committee. No hearings were held, nor testimony received.

The Committee proceeded to consider H.R. 1836 on April 1, 1998. A technical amendment to section 4 was offered by Senator Cochran. The amendment changed certain dates in Section 4 of the bill to recognize that the health plans currently offered to employees by the Federal Reserve and the Federal Deposit Insurance Corporation did not cease to exist in January 1998. Those agencies may now terminate those health plans before January 3, 1999, thereby allowing employees of those agencies to enroll in the Federal Employee Health Benefits Program. The amendment was adopted by voice vote. H.R. 1836, as amended, was considered en bloc with other legislation and was reported favorably to the full Senate by a recorded vote of 9–0. Voting in the affirmative were Senators Akaka, Cleland, Durbin, Glenn, Levin, Cochran, Nickles, Roth, and Thompson.

III. Need for Legislation

H.R. 1836, as amended by the Committee, addresses several areas of operation of the Federal Employees Health Benefits Program. The legislation provides the Office of Personnel Management with additional ways of fighting waste, fraud, and abuse in the program. Thus, OPM will be equipped to deal effectively with health care providers who participate in fraudulent activities affecting the FEHBP. In addition, the legislation permits certain employees of the Federal Deposit Insurance Corporation and the Federal Reserve Board to participate in the FEHBP, establishes statutory requirements regarding the readmitting of health care plans sponsored by employee organizations that have previously discontinued participation in the FEHBP, and increases the max-

imum amount of the physicians' comparability allowance from $20,000 to $30,000. These changes improve the operation of the program to the benefit of program enrollees, carriers, taxpayers and the federal government.

One area of program operation addressed by H.R. 1836 involves the practice of plan carriers contracting with third parties to obtain [*3] discounts from health care providers. The Committee recognizes the important role that Preferred Provider Organizations (PPOs) play in today's health care market. Frequently, the PPOs negotiate discounted rate schedules with health care providers in exchange for certain incentives. The incentives may include an agreement to steer patients to the provider, in the case of so-called "directed PPOs," or they may include financial incentives such as prepayment or prompt payment in the case of so-called "non-directed PPOs." Both directed and non-directed PPOs provide legitimate and valuable benefits to health care providers, carriers, and patients.

Based upon concerns raised to the House Government Reform and Oversight Committee by the American Medical Association and the American Hospital Association that certain payers were taking advantage of discounts to which they were not entitled, the Office of Personnel Management Inspector General was requested to conduct a review ". . . to determine whether silent PPOs were used by FEHBP carriers to capture discounts to which they were not entitled." That report is included in the Additional Views submitted by Senator Thad Cochran, Chairman of the Subcommittee on International Security, Proliferation and Federal Services.

Under this bill, OPM must encourage carriers to seek assurances from any person with whom they contract to obtain discounted rates from providers that the conditions for such discounts are fully disclosed to the providers who grant them. Further, the Committee recognizes the necessity of the existence of contracts between providers and networks, and the benefits that PPO arrangements provide the FEHBP.

IV. Section-by-Section Analysis

SECTION 1. SHORT TITLE

This Act may be cited as the "Federal Employees Health Care Protection Act of 1998".

SECTION 2. DEBARMENT AND OTHER SANCTIONS

Section 2 relates to debarment and other sanctions on health care providers in the Federal Employees Health Benefits Program (FEHBP).

Definitions

Current law.—Defines the terms "provider of health care," "individual covered under this chapter," and "convicted."

H.R. 1836.—Retains these definitions and adds another for "should know,"—"a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required."

Authority to debar

Current law.—The Office of Personnel Management (OPM) has permissive authority to debar, i.e., exclude certain providers of health care services or supplies from participating in the FEHBP.

[*4] *H.R. 1836.*—Retains permissive authority to debar, but adds mandatory authority to debar.

Grounds for debarment

Current law.—OPM may debar any provider that has been convicted, under federal or state law, or a criminal offense—

(1) relating to fraud, corruption, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care service or supply;

(2) relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

(3) in connection with the interference with or obstruction of an investigation or prosecution of a criminal offense described in (1) or (2); or

(4) relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

OPM also may debar any provider—

(1) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed by a state licensing authority for reasons relating to the provider's professional competence or performance or financial integrity; or

(2) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned competence, performance, or financial integrity.

H.R. 1836.—Changes permissive debarment to mandatory for any provider convicted of criminal matters cited in grounds 1–4 above.

Further, this provision adds an additional ground for mandatory debarment for any provider that currently is suspended or excluded from participation under any program of the federal government involving procurement or no procurement activities.

The section retains the permissive debarment for the above grounds relating to professional licensing.

The section adds four additional grounds for permissive debarment for—

(1) any provider that is an entity directly or indirectly owned, or with a five percent or more controlling interest, by an individual who was convicted of any offense that is a ground for mandatory debarment, against whom a civil monetary penalty has been assessed, or who has been debarred from participating in FEHBP;

(2) any individual who directly or indirectly owns or has a controlling interest in an entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense for which mandatory debarment may be imposed, assessment with a civil penalty, or debarment from participation;

(3) any provider that OPM determines, in connection with claims presented, has charged for health care services or supplies in an amount substantially in excess of the provider's customary charges for such services or supplies (unless OPM finds there is good cause for such a charge) or has charged for health [*5] care services or supplies substantially in excess of the needs of

the covered individual or which are of a quality which fails to meet professionally recognized standards for the services or supplies; or

(4) any provider that OPM determines has committed acts for which a civil penalty may be imposed.

Consequence of debarment

Current law.—No payment may be made by a carrier pursuant to any FEHBP contract to a provider that is barred from participating in the program for any service or supply furnished by the provider during the period of debarment.

H.R. 1836.—No change.

Authority for civil penalties and additional sanctions

Current law.—OPM has permissive authority to impose, in addition to other penalties that may be prescribed by law, and after consulting with the Attorney General, a civil monetary penalty of not more than $10,000 for any item or service involved.

In addition, a provider against whom a civil penalty has been imposed is subject to a mandatory assessment of not more than twice the amount claimed for each item or service.

Moreover, OPM has permissive authority in the same proceeding to bar such provider from participating in FEHBP.

H.R. 1836.—No change.

Grounds for imposing civil penalties and additional sanctions

Current law.—OPM has permissive authority to impose a monetary civil penalty, mandatory authori-

ty to impose an assessment, and permissive authority to debar whenever it determines—

(1) in connection with a claim presented under FEHBP, that a provider of health care services or supplies has charged for health care services or supplies—

(A) that the provider knows or should have known were not provided as claimed; or

(B) in an amount substantially in excess of the provider's customary charges or substantially in excess of the needs of the covered individual or are of a quality that fails to meet professionally recognized standards for such services or supplies;

(2) has knowingly made, or caused to be made, any false statement of a material fact which is reflected in an FEHBP claim; or

(3) has knowingly failed to provide any information to a carrier or to OPM to determine whether a payment or reimbursement is payable under FEHBP or the amount of any such payment or reimbursement.

H.R. 1836.—Amends paragraph (1) above by substituting "claims" in place of "claim," retaining (A), deleting (B), and replacing it with two grounds for any provider that has charged for a health care service or supply which the provider knows or should have known involves—

(B) charges in violation of applicable charge limitations under 5 U.S.C. section 8904(b) relating to Medicare; or **[*6]**

(C) an item or service furnished during a period when the provider was excluded from partic-

ipation in FEHBP pursuant to a determination by OPM, other than as permitted under subsection (g)(2)(B) relating to postponing the effective date of a debarment.

Time limitation on debarment or imposing civil penalties

Current law.—OPM may not initiate any debarment proceeding based on a criminal conviction later than six years after a provider was convicted and may not impose a civil penalty, assessment, or debarment later than six years after the date a claim meriting a civil penalty is presented.

H.R. 1836.—No change.

Factors to be considered in debarment or imposing civil penalties

Current law.—In determining the appropriateness of imposing debarment, a period of debarment, or a civil penalty, OPM is required to take into account—

(1) the nature of any claims involved and the circumstances under which they were presented;

(2) the degree of culpability, history of prior offenses or improper conduct of the provider involved; and

(3) such other matters as justice may require.

H.R. 1836.—Limits consideration of these factors only to cases where debarment is permissive or to civil penalties; it does not require considering them for mandatory debarments.

Effective date of debarment

Current law.—Debarment of a provider under permissive debarment authority or in connection with a civil penalty is effective at such time and upon such reasonable notice to the provider and to carriers and covered individuals as specified by OPM regulations. Debarment is effective for any health care services or supplies furnished by a provider on or after the effective date of debarment, except for inpatient services to an individual who was admitted to the institution before the date of debarment until 30 days after that date, unless OPM determines a shorter period is necessary in order to protect the health or safety of the individual receiving those services.

Any notice of debarment must specify the date the debarment will become effective and the minimum period it will remain in effect.

H.R. 1836.—In most circumstances, under mandatory and permissive debarment authorities, the debarring official has authority to determine the effective date of debarment without regard to a hearing. Any provider may request a hearing after the effective date of debarment. However, in the case of permissive debarments on the grounds that would subject the provider to civil monetary penalties, OPM cannot make a determination which is adverse to a provider until the provider has been given reasonable notice and an opportunity for the determination to be made after a hearing. The hearing must occur before the adverse action is taken, unless OPM determines that the health or safety of individuals receiving health care warrants an earlier date.

[*7] *Period of debarment*

Current law.—Generally, the minimum period as specified by OPM regulation. Existing law does not mandate a minimum period of debarment.

H.R. 1836.—Generally imposes that providers convicted under federal or state law of specified offenses must be debarred for at least three years. Those offenses include:

(1) fraud, corruption, breach of fiduciary responsibility or other financial misconduct;

(2) neglect or abuse of patients;

(3) interference with or obstruction of an investigation or prosecution of a criminal offense described in paragraphs (1) and (2) above;

(4) a criminal offense relating to the manufacture, distribution, prescription, or dispensing of a controlled substance.

Termination of debarment

Current law.—A provider permissively barred from participating in the FEHBP may, *after* the expiration of the minimum period of debarment specified in the notice, apply to OPM for termination of debarment. OPM may terminate the debarment after the end of the minimum debarment period if it determines that there is no basis under the permissive debarment authority or the civil penalty authority for continuing the debarment and there are reasonable assurances that the types of action which formed the basis for the original debarment have not recurred or will not recur.

OPM may terminate the debarment of a provider before the expiration of the minimum debarment pe-

riod if it determines that there is no basis for continuing the debarment, there are reasonable assurances that such behavior has not and will not recur, and early termination is warranted because the provider is the sole community provider or the sole source of essential specialized services in a community.

H.R. 1836.—Authorizes OPM to terminate a mandatory debarment after the minimum debarment period if it determines that there is a no basis under mandatory debarment authority for continuing the debarment.

Notice and hearing requirements and judicial review

Current law.—OPM may not make a determination under permissive debarment authority or civil penalty authority adverse to a provider until after the provider has been given written notice and an opportunity for a hearing, i.e., a pre-adverse action hearing. Any person adversely affected by an OPM final adverse decision may obtain review of the decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting modification or setting aside of OPM's decision must be filed within 60 days after the provider is notified.

H.R. 1836.—Amends this provision by substituting that any provider that is subject of an adverse OPM determination is entitled to reasonable notice and an opportunity to request a hearing of record, i.e. a post-adverse action hearing of record. OPM is required to grant a request for a hearing upon a showing that due process [*8] rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination.

Such a hearing is conducted without regard to subchapter II of chapter 5 of title 5, United States

Code, relating to administrative procedure, and chapter 7 of title 5, relating to judicial review. The hearing is conducted by a hearing officer who is appointed by the Director of OPM. A request for a hearing is required to be filed within such a period and in accordance with procedures as prescribed by OPM.

Any provider adversely affected by a final decision made after a hearing may seek review in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his principle place of business by filing an appeal within 60 days from the date the decision is issued.

The court has power to enter, upon the pleadings and record, a judgment affirming, modifying, or setting aside, in whole or in part, OPM's decision, with or without remanding the cause for a hearing. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record to support the findings of OPM or unless the action taken by OPM constitutes an abuse of discretion.

Venue of civil penalty actions

Current law.—A civil action to recover civil monetary penalties or assessments must be brought by the Attorney General and may be brought in the district court where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered are paid to OPM for deposit into the Employees Health Benefits Fund.

H.R. 1836.—Retains current law and adds that the amount of a penalty or assessment as determined by OPM, or other amount OPM may agree to in compromise, may be withheld from any sum then or later

owing by the United States to the party against whom the penalty or assessment has been levied.

Effective dates

Current law.—Not applicable.

H.R. 1836.–With three exceptions, the amendments made by H.R. 1836 take effect on the date of enactment.

The first exception relates to permissive debarment under specified circumstances and applies only to the extent that the misconduct which is the basis for the permissive debarment occurs after the date of enactment.

The second exception involves civil monetary penalties and assessments for violations of charge limitation relating to Medicare and applies only for charges for items or services furnished after the date of enactment.

The third exception relates to the minimum three year period of mandatory debarment for grounds prescribed in the mandatory debarment section and applies only with respect to criminal convictions that occur after enactment.

[*9] SECTION 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

Current Law.—Does not specify that an association of organizations may serve as the carrier for any health benefits plan in the FEHBP. It also does not specify that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia.

H.R. 1836.—Amends the definition of "carrier" and the description of the government-wide Service Benefit Plan under current law. Additionally, H.R. 1836 broadens the preemption provisions in current law to enable national plans to offer uniform benefits and rates to enrollees regardless of where they live.

Specifically, section 3 does the following:

Amends paragraph (7) of section 8901, title 5, U.S.C. by striking "organization" and inserting "organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan."

Amends paragraph (1) of section 8903, title 5, U.S.C. by striking "plan" and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States."

Amends section 8902(m) of title 5, U.S.C. by striking "(m)(1) and all that follows through that paragraph, and inserting "(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plan."

SECTION 4. CONSISTENT COVERAGE FOR INDIVIDUALS ENROLLED IN A HEALTH PLAN ADMINISTERED BY THE FEDERAL BANKING AGENCIES

Current law.—Requires that federal retirees must have participated in the FEHBP for at least five years immediately preceding retirement in order to be eligible to participate in the FEHBP as a retiree and for certain continuation of coverage upon separa-

tion from service. In recent years, the Federal Reserve Board, the Federal Deposit Insurance Corporation, the Office of the Comptroller of the Currency, and the Office of Thrift Supervision have sponsored their own health insurance plans for their employees. These agencies are now dropping those plans and participating in the FEHBP. P.L. 103–409 allowed employees of the Office of the Comptroller of the Currency and the Office of Thrift Supervision to participate in the FEHBP if they had been enrolled in their agency's plan before separation in order to meet the five year requirement.

H.R. 1836.—Would deem participation in a health insurance plan sponsored by the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System to meet the enrollment requirements for participation in the FEHBP as retirees or under continuation of coverage conditions. it would require these federal banking agencies to make a payment to the FEHBP fund to cover the government's share of premium costs for retirees who would, by the Act, be made eligible for FEHBP coverage as an annuitant.

[*10] In an amendment adopted by the Committee, the effective dates for the transition in the FEHBP is changed from "on January 3, 1998" to "on or before January 2, 1999" to ensure that the transition in the FEHBP is limited only to those Federal Reserve and FDIC employees who were participating in the health care plans that those agencies are now terminating. In addition, this amendment reflects the fact that the health plans currently offered to employees by the Federal Reserve and the FDIC did not cease to exist in January 1998; and that those agencies may now terminate those health plans any-

time before January 3, 1999 thereby allowing employees to move into the FEHBP.

SECTION 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS

Current law.—Does not have a full disclosure requirement.

H.R. 1836.—Directs OPM to encourage carriers who obtain provider discounts to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SECTION 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP

Current Law.—Does not allow health care plans sponsored by an employee organization to reenter the FEHBP after previously discontinuing its participation. Additionally—with respect to the contingency reserves of the discontinued plans—OPM is required to distribute those reserves to plans continuing in the FEHBP in the contract year after the discontinuance.

H.R. 1836.—Amends chapter 89 of title 5 by adding the following after section 8903(a): 8903(b). Authority to readmit an employee organization plan.

In the event that a plan described by section 8903(3) or 8903a is discontinued (other than in the circumstance described in section 8909(d)), the plan may be reconsidered for FEHBP eligibility for any contract year after the third contract year in which the plan was discontinued.

Subsection (e) of section 8909 of title 5, U.S.C., is amended by striking "(e) and inserting "(e)(1)" and by adding language that requires OPM to distribute the

contingency fund reserves of certain discontinued plans within 2 contract years.

SECTION 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE

Current Law.—In 1978 the Federal Physicians Comparability Act, PL 95–603, was passed and provided a maximum of $10,000 per year in additional compensation for one year of service for physicians where significant recruitment and retention problems exist. In 1987 the maximum physicians comparability allowance (PCA) as increased by Congress to $20,000 per year. These provisions are codified in 5 U.S.C. 5948 and implementing regulations were issued by OPM in 5 C.F.R. 595.

H.R. 1836.—Increases the maximum physicians comparability allowance Federal agencies may pay from $20,000 to $30,000 per year.

[*11] SECTION 8. CLARIFICATION RELATING TO SECTION 8902(K)

Current Law.—Requires carriers offering health benefit plans under the FEHBP to provide for direct payment for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/ clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11).

H.R. 1836.—Amends section 8902(k) of title 5, U.S.C., by inserting after paragraph (1) language ensuring that no health benefits plan is precluded from providing direct access or direct payments for services provided by a health care professional not listed in paragraph (1), as long as the professional is li-

censed or certified as such under Federal or State law.

V. Estimated Cost of Legislation

U.S. Congress,

Congressional Budget Office,

Washington, DC, June 1, 1998.

Hon. Fred D. Thompson,

Chairman, Committee on Governmental Affairs, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1836, the Federal Employees Health Care Protection Act of 1998.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts for the federal budgetary impact are Tom Bradley (for the Federal Employees Health Benefits program), Mary Maginniss (for the Federal Deposit Insurance Corporation) and John R. Righter (for federal pay), and Mark Booth (for the Federal Reserve). The CBO staff contact for the state and local impact is Leo Lex.

Sincerely,

June E. O'Neil, *Director.*

Enclosure.

Congressional Budget Office Cost Estimate

H.R. 1836—Federal Employees Health Care Protection Act of 1998

Summary: H.R. 1836 would modify the administration of the Federal Employees Health Benefits

(FEHB) program, transfer the health coverage of retirees and certain active employees of the Federal Deposit Insurance Corporation (FDIC) and the Board of Governors of the Federal Reserve to the FEHB program, and raise the pay of certain physicians employed by the federal government. CBO estimates that the legislation would reduce direct spending by $54 million and federal revenues by $7 million over the 1999–2003 period. Consequently, pay-as-you-go procedures would apply to the legislation. In addition, CBO estimates that implementing H.R. 1836 would increase discretionary outlays by $30 million over the 1999–2003 period, assuming appropriation of the necessary amounts.

[*12] H.R. 1836 would expand a preemption of state and local authority to regulate health care plans that provide coverage under FEHB. This preemption would be considered a mandate under the Unfunded Mandates Reform Act (UMRA). However, because the preemption would simply limit the application of state law in some circumstances, CBO estimates that any costs to state or local governments arising from this mandate would be minimal. H.R. 1836 contains no private-sector mandates as defined in UMRA.

Estimated Cost to the Federal Government: The estimated budgetary impact of H.R. 1836 is shown in the following table. This estimate assumes that the legislation will be enacted by the start of fiscal year 1999. The legislation would effect governmental receipts and outlays in several budget functions.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003
CHANGES IN DIRECT SPENDING						
FDIC:						
Estimated budget authority ...	0	0	0	0	0	0
Estimated outlays	0	160	-14	-15	-18	-20
FEHB:						
Estimated budget authority ...	0	-178	6	7	8	10
Estimated outlays	0	-178	6	7	8	10
Total Changes in Direct Spending:						
Estimated budget authority ...	0	-178	6	7	8	10
Estimated outlays	0	-18	-8	-8	-10	-10
CHANGES IN REVENUES						
FEBH Coverage for Federal Reserve:						
Estimated revenues	0	-11	1	1	1	1

SPENDING SUBJECT TO APPROPRIATION

Spending on Physicians Comparability Allowance Under Current Law:[4]						
Estimated budget authority ...	27	27	27	27	14	0
Estimated outlays	27	27	27	27	14	1
Proposed changes:						
Estimated authorization level ...	0	7	9	9	5	0
Estimated outlays.....	0	7	9	9	5	([5])
Spending on Physicians Comparability Allowance Under H.R. 1836:						
Estimated authorization level ...	27	34	36	36	19	0
Estimated outlays	27	34	36	36	19	1

[4] Under current law, agencies can offer allowances to physicians through fiscal year 2000, with the contracts for such allowances extending through fiscal year 2002.

[5] Less than $500,000.

Basis of estimate: By modifying the health coverage of FDIC and Federal Reserve retirees and active employees within five year of retirement, H.R. 1836 would affect both direct spending (for the FIC and the FEHB program) and revenues (for the Federal Reserve). In addition, increasing the pay of certain physicians employed by the government would affect discretionary spending.

Direct spending and Revenues

Health Insurance Transfer for Certain Employees. H.R. 1836 would transfer the health insurance coverage of retirees and certain active employees of the FDIC and the Board of Governors of the Federal Reserve System to the FEHB program. Currently, those two agencies operate their own health insurance programs. The legislation would also require the two agencies to make a one-[*13]time payment to the Office of Personnel Management (OPM), which administers the FEHB program, to cover the long-term cost of the government's contribution toward the insurance premiums of the newly covered individuals.

The shifting of the FDIC employees and retirees to the FEHB program would reduct direct spending in each year because the FDIC pays more for health insurance than the FEHB program would. The current FDIC plan is more expensive that the typical FEHB plan because the insured employees are older and fewer in number, and it provides more general coverage. Ongoing savings would grow form an estimated $7 million in fiscal year 1999 to $11 million in 2003. CBO assumes that the FDIC would make the required one-time payment to OPM in January 1999. We estimate that the one-time payment would be $170 million; but we also estimate that the FDIC

would save $10 million in the same year from lower health insurance costs. The net cost to the FDIC in 1999, therefore, would be $160 million. Reflecting the transfer from the FDIC, the FEHB program would receive the payment of $170 million in that year but would incur additional costs of about $3 million to insure those employees and retirees, for new savings of $167 million to the FEHB program.

The transfer between the Federal Reserve and the FEHB program would have a similar effect, but significantly fewer employees would be affected at the Federal Reserve. We estimate that the Federal Reserve would make a one-time payment of $12 million to OPM in 1999, with associated savings of $1 million, for a net reduction in revenues of $11 million. The associated savings to the Federal Reserve and costs to the FEHB program beyond 1999 would both approximate $1 million per year, although FEHB costs may be slightly less and the Federal Reserve's savings slightly more. Also, the budgetary effects on the Federal Reserve are re-corded on the revenue side of the budget. Thus, the resulting increases in federal revenues beyond 1999 would approximate the increase in FEHB costs for coverage of Federal Reserve personnel, and the net budgetary impact each year would be negligible.

Other Provisions. CBO estimates that the other provisions of H.R. 1836 would not significantly affect FEHB spending. The legislation would strengthen OPM's ability to bar or sanction unethical health providers and expand a preemption of state and local authority to regulate health plans that provide coverage under FEHB. Enacting those provision might reduce FEHB costs slightly.

H.R. 1836 also would require OPM to encourage carriers to seek assurances that health care providers who contract with third parities to provide discounted rates are made aware of the conditions for those discounts. That provision could discourage some FEHB plans from using certain discount vendors, potentially increasing costs. Based on a survey conducted by OPM, however, FEHB plans believe that their discount vendors disclose the conditions of the discount to health care providers.

Finally, section 8 would allow plans to make direct payments to certain non-physician providers, even when such arrangements are not required by law. Because plans already have such authority, the enactment of that section would not affect FEHB spending.

[*14] *Spending subject to appropriation*

H.R. 1836 would increase the maximum annual allowance payable to eligible federal physicians to $30,000. Current law authorizes certain agencies to pay allowances of up to $20,000 a year to recruit and retain physicians for certain positions, such as those with long-term vacancies or high turnover rates. To receive the allowance, physicians must agree to work at least one year at the agency. CBO estimates that increasing the maximum annual allowance from $20,000 to $30,000 would increase salary costs by $30 million over the 1999–2003 period. This estimate is based on information provided by OPM, including data on the number of federal physicians receiving comparability allowances and the average annual premium that they receive under current service agreements. CBO estimates that the provision would increase the average allowance for 1,800 physicians by about $5,000 a year and that agencies

would modify service agreements with physicians within the few months of fiscal year 1999.

The authority for agencies to offer allowances to physicians was extended through fiscal year 2000 by the Treasury and General Government Appropriations Act for fiscal year 1998 (Public Law 105–61). Under that authority, agencies and physicians can enter into contracts that extend through the end of fiscal year 2002. Most service agreements are made for two years. CBO assumes that the number of outstanding contracts in fiscal year 2001 will approximate the number of contracts in 2000, and that the number of contracts in fiscal year 2002 will be about one-half of the number estimated for 2001. Thus, the increase in costs for fiscal year 2002 is lower than for previous years.

Pay-as-you-go consideration: The Balances Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governments receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

The budget excludes from pay-as-you-go calculations expenses associated with maintaining the deposit insurance commitment. CBO assumes that the increase in costs to the FEHB program and the decreases to the FDIC from its employees joining the FEHB plan would be excluded from the pay-as-you-go calculations because they would be associated with maintaining the deposit insurance commitment. The budgetary effects on the Federal Reserve, and

the corresponding effect on outlays of the FEHB program, would not be excluded.

[By fiscal year, in millions of dollars]

	19-98	19-99	20-00	20-01	20-02	20-03	20-04	20-05	20 06	20-07	20-08
Changes in outlays	0	–11	1	1	1	1	1	1	1	1	1
Changes in receipts	0	–11	1	1	1	1	1	1	1	1	1

Estimated impact on state, local, and tribal governments: H.R. 1836 would add language expanding the preemption of state and local authority to regulate health care plans that provide coverage [*15] under the FEHB program. Current law prohibits state and local governments from regulating the nature and extent of coverage and benefits for people covered by the FEHB program if the regulation of law is inconsistent with the contract provisions. The new language would preclude state and local governments from regulating the provision of coverage or benefits as well, and it removers the language dealing with inconsistencies, thereby giving the federal contract provisions clear authority. These changes would affect states that have requirements governing what types of organization can provide health care when those requirements are different from those under federal contracts. This preemption would be considered a mandate under UMRA. However, because the only effect of the preemption would be to limit the application of state law in some cir-

cumstances, CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

Estimated impact on the private sector: H.R. 1836 contains no private-sector mandates as defined in UMRA.

Previous CBO estimate: On November 3, 1997, CBO prepared a cost estimate for H.R. 1836, as ordered reported by the House Committee on Government Reform and Oversight on October 31, 1997. For the House version of H.R. 1836, CBO did not estimate any effect on direct spending or governmental receipts. This estimate corrects that error.

Estimate prepared by: Federal Costs: Tom Bradley, FEHB, Mary Maginniss, FDIC, Mark Booth, Federal Reserve, and John R. Righter, federal pay.

Impact on State, local, and Tribal governments: Leo Lex. Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

VI. Evaluation of Regulatory Impact

Pursuant to the requirement of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee has considered the regulatory and paperwork impact of H.R. 1836. The Committee reports that section only 3 of H.R. 1836, making technical changes regarding national plans, would result in a mandate, but costs to state and local government have been estimated by CBO to be minimal. Provisions of the bill relating to health insurance [section 3(c)] would preempt all State and local laws that relate to health insurance or plans. Section 2 of H.R. 1836 should reduce administrative burdens on the Office of Personnel Management by streamlining the debarment process. In general, OPM would be

permitted to debar a provider prior to a hearing being held. Section 4 of H.R. 1836 would reduce the administrative burdens on both the Federal Reserve and the FDIC by enabling them to avoid maintenance of a non FEBH program plan for Federal Reserve and FDIC employees currently ineligible for FEHBP coverage. Under H.R. 1836, these ineligible individuals will be offered FEHBP coverage at no cost to the Federal government. [*16]

VII. Additional Views of Senators Cochran, Glenn, and Levin

At the request of the House Subcommittee on Civil Service, the Office of Personnel Management Inspector General (OPM IG) conducted a study to determine whether silent Preferred Provider Organizations (PPOs) were used by Federal Employee Health Benefit Plan (FEHBP) carriers to capture discounts to which they were not entitled. In brief, the IG found no evidence that health care providers were being victimized by FEHBP carriers, nor any evidence of schemes allowing payers to capture discounts they are not contractually entitled to receive. Although we support inclusion in H.R. 1836 of section 5 bill language, we believe Congress should be careful to avoid interjecting the federal government into contractual issues between health care providers and health plans.

A recent audit by the OPM IG defined "Silent" PPOs as a health care provider discount taken by a FEHBP carrier without a contract existing between the PPO and the health care provider. This is the type of unethical practice that the FEHBP carriers should avoid.

Further, PPOs, both directed and non-directed, provide various incentives to health care providers which contract with PPOs for the benefit of FEHBP, i.e., to re duce health care costs. The FEHBP must continue to benefit from these relationships, recognizing that the PPOs must always have a contract with the health care provider.

Attached is the February 26, 1998 report of the OPM IG, as submitted to Congress, by Patrick E. McFarland, Inspector General, Office of Personnel Management.

CARL LEVIN.
JOHN GLENN.
THAD COCHRAN.

[*17] OFFICE OF PERSONNEL MANAGEMENT,
Washington, DC, February 26, 1998.

Hon. THAD COCHRAN,

Chairman, Subcommittee on International Security, Proliferation and Federal Services, Senate Committee on Governmental Affairs, Washington, DC.

DEAR CHAIRMAN COCHRAN: As a result of interest initially expressed by Chairman Mica, House Subcommittee on Civil Service, Committee on Government Reform and Oversight, the Office of Personnel Management (OPM), Office of the Inspector General (OIG) has performed a review of the use of "silent" and "non-directed" Preferred Providers Organizations (PPOs) in the Federal Employees Health Benefits Program (FEHBP). Our report is enclosed. The committee expressed the concerns of the American Hospital Association and American Medical Association who suggested that health care providers are being victimized by schemes that create payment discounts for payers who are not entitled to them.

These schemes are purportedly carried out by "silent PPOs." Thus, the principal purpose of our review was to determine whether "silent PPOs" were used by FEHBP carriers to capture discounts to which they were not entitled. Our review did not disclose any evidence that FEHBP carriers used "silent PPOs" to capture discounts or that health care providers were otherwise victimized by FEHBP carriers. Nevertheless, we observed that for 1.3 percent of the claims we tested, discounts taken were inconsistent with agreed upon contract terms. We do not consider these errors to be material nor are they indicative of a systemic problem.

At the request of the committee, we also determined how wording in OPM's annual carrier call letter, which encouraged carriers to seek discounts on providers' bills, came to be included in the call letter. We found that the wording was included as a result of discussions between House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A copy of this report has been sent to Representative Dan Burton, Chairman, Committee on Government Reform and Oversight. If you need any additional information related to this review, please call me, or have a member of your staff call Harvey D. Thorp, Assistant Inspector General for Audits.

Sincerely,

PATRICK E. MCFARLAND, *Inspector General.*

Enclosure.

[*18]

REPORT OF REVIEW

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

REPORT ON THE USE OF SILENT PPOs
IN THE
FEDERAL EMPLOYEES HEALTH BENEFITS
PROGRAM

REPORT NUMBER 99-00-97-054
DATE February 26, 1998

s/
Harvey D. Thorp
Assistant Inspector General for
Audits

-- CAUTION --

This audit report may contain proprietary data which is protected by Federal law (18 USC 1905); therefore, while this report is available under the Freedom of Information Act, caution should be exercised before releasing the report to the public.

[*19]

Report Number 99-00-97-054

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

REPORT ON THE USE OF SILENT PPOs IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

I. INTRODUCTION AND SUMMARY OF RESULTS

As a result of interest initially expressed by Chairman Mica, House Subcommittee on Civil Service, Committee on Government Reform and Oversight, the Office of Personnel Management (OPM), Office of the Inspector General (OIG) has performed a review of the use of "silent" and "non-directed" Preferred Providers Organizations (PPOs) in the Federal Employees Health Benefits Program (FEHBP). The committee expressed the concerns of the American Hospital Association and American Medical Association who suggested that health care providers are being victimized by schemes that create payment discounts for payers who are not entitled to them. These schemes are purportedly carried out by "silent PPOs." Thus, the principal purpose of our review was to determine whether "silent PPOs" were used by FEHBP carriers to capture discounts to which they were not entitled. Our review did not disclose any evidence that FEHBP carriers used "silent PPOs" to capture discounts or that health care providers were otherwise victimized by FEHBP carriers. Nevertheless, we observed that for 1.3 percent of the claims we tested, discounts taken were inconsistent with

agreed upon contract terms. We do not consider these errors to be material nor are they indicative of a systemic problem.

At the committee's request, we also determined how wording in OPM's annual carrier call letter, which encouraged carriers to seek discounts on providers' bills, came to be included in the call letter. We found that the wording was included as a result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A detailed discussion of our review objectives, scope, and methodology is presented in Section IV. Substantive comments made in response to a draft of this report from several affected parties are included in the appendix.

II. BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86 382), enacted on September 28, 1959. The FEHBP was created to provide health insurance [*20] benefits for federal employees, annuitants, dependents, and others. OPM's Retirement and Insurance Service has overall responsibility for administration of the FEHBP. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers that provide either service benefits, indemnity benefits, or comprehensive medical services. Health insurance carriers provide these benefits on either a fee-for-service or a prepaid basis. For

calendar year 1997, there were 14 fee-for-service plans and about 460 prepaid plans in the FEHBP. In a fee-for-service plan, the medical provider is paid a fee for the specific service provided. The size of the fee will vary depending on the complexity of the service. The subscriber's group insurance premiums reflect the composite cost of all fees paid to medical providers on behalf of all subscribers in the group. In a prepaid plan, the providers are generally paid a fixed amount which is intended to cover all the services required by individual subscribers. Because of the fixed nature of the payment, the providers are at risk of not recovering all their costs. This risk is an incentive for prepaid plans to control their costs.

During the last decade, the health insurance industry has been undergoing rapid change in response to rising costs. The rapid growth of prepaid health carriers, generally referred to as Health Maintenance Organizations (HMO), who, through their ability to better control costs via utilization control and managed care techniques, have caused fee-for-service carriers to seek better ways and means to control their costs so that they can remain competitive. One cost control method used by fee-for-service carriers is known as a Preferred Provider Organization (PPO). A PPO is a group of medical providers who agree to provide medical services to the subscribers of an insurance carrier at a lesser cost than would have been otherwise charged. The perception is that in a traditional PPO, the PPO would employ some method of controlling benefit utilization by subscribers and would manage medical care more cost effectively. They might also establish controls to improve the quality of care. In exchange for a preferred status, lower fees, and better care, the carrier would attempt to steer its subscribers to the PPO's medical provid-

ers through such methods as financial incentives, ID cards, and preferred provider lists. Thus, significant savings could be achieved by the carrier which would reduce its premium costs.

In recent years, a new variation of the PPO concept appeared. This variation is known as a "non-directed" PPO as distinguished from the traditional PPO which has become known as a "directed" PPO. The terms "directed" and "non-directed" are references to the steerage or lack of steerage of patients. As explained above, in a traditional directed PPO arrangement, subscribers are steered to the PPO to take advantage of the lower costs. In a "non-directed" PPO, even though the medical providers have agreed to charge a lower fee, the contract the PPOs enter into do not require that the carrier's subscribers be steered to them. In some non-directed PPOs, the PPO may benefit from this arrangement as a result of prompt payments or advances. In other non-directed PPO arrangements, the benefits to the provider may be less clear.

In the case of both the directed and non-directed PPOs, the terms of the arrangement are committed to a contract between the parties. Also, there may be intermediate organizational [*21] layers between the insurance carrier and the providers of medical service. In a typical non-directed arrangement in the FEHBP, an insurance carrier contracts with a third party vendor for non-directed PPO services. The vendor assembles the network of non-directed PPO providers by either contracting directly with individual medical providers or by contracting with networks of medical providers who in turn contract with individual medical providers (Exhibit 1). Very frequently, the vendors and the provider networks also

contract with other carriers for directed PPOs. Therefore, non-directed PPO services may be provided to FEHBP carriers while directed PPO services may be provided by the same provider or provider network to non-FEHBP insurance carriers.

Concurrent with the evolution of non-directed PPOs, a new term, "silent PPO" became commonplace. The term, "silent PPO," means different things to different people. Initially, the term "silent PPO" was merely a reference to a non-directed PPO where the contract was "silent" with regard to the steerage of patients to the provider's facilities. However, in more recent times, the term has acquired a more restrictive meaning. As a result, to some people, "silent PPO" describes a payment scheme used to obtain illegal discounts for payers who are not entitled to them. In discussions with interested parties and in industry literature, the terms "fraud," "illicit," "manipulation," "falsely," "unethical," and "scheme" are frequently used to describe silent PPOs. Consequently, the term "silent PPO" has come to mean an unethical and/or illegal practice, and the term has been loosely extended to inappropriately encompass non-directed PPOs. For the purpose of our review, we have differentiated between the terms "non-directed PPO" and the more restrictive term "silent PPO." Since "silent PPO" activity would be inappropriate for the FEHBP, we were concerned with the implication that it may exist in the FEHBP.

A "silent" PPO is distinguished from a "non-directed" PPO by the nature of the contractual relationship between the parties. As stated above, in a "non-directed" relationship, discounts are taken pursuant to contractual arrangements that can be traced from the payer (i.e., the insurance carrier) to

the medical provider. In a "silent PPO," a contractual relationship can not be traced from the payer to the medical provider from whom the discount is taken. Typically, in a silent PPO arrangement, another PPO will sell its medical provider's names and discounted fee information, often without the provider's knowledge and permission, to a secondary market of vendors. These vendors then access the information on behalf of their payer clients, recalculating the provider's fee based on the discounted fee information. It has been alleged that sometimes, the payer may claim a non-existent affiliation with the provider by inaccurately declaring that the patient is a member of a PPO to which the provider is a member.

In 1993, when the distinction between a non-directed PPO and a silent PPO was less clear, OPM became aware of market place arrangements that resulted in the capturing of discounts from provider bills. As a result, in its March 1993 call letter to FEHBP carriers providing rate and benefits instructions for the 1994 contract year, OPM stated, "In addition, OPM is aware that price concessions are available from non-network providers, e.g., hospitals, so carriers are expected to obtain the lowest price available for all goods and services, including non-PPO [*22] providers." The committee is concerned that this OPM requirement may have encouraged the use of improper payment discounts thereby causing an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give.

III. DISCUSSION OF RESULTS

Our review disclosed that substantial savings have been and can be achieved by both directed and non-directed PPOs. We further found these saving

can be achieved in an ethical manner; in that, we found no evidence in the FEHBP that "silent PPOs" were a factor or that provider discounts were otherwise taken on the basis of any schemes to victimize medical providers. In addition, we found FEHBP carriers and their vendors were, except for some minor exceptions, accessing discounts in accordance with the terms of their contracts with providers. Based upon the aggregate of our observations, we believe given the complex environment in which PPOs operate, it is understandable why the expectations for patient steerage by medical providers is not always fulfilled. With regard to OPM's call letter, we found that language which encouraged carriers to seek discounts on providers' bills was the result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A. Substantial Savings Can Be Achieved through both Directed and Non-directed Preferred Provider Arrangements

As we indicated earlier, a principal reason why carriers enter into preferred provider arrangements is to reduce their costs. Lower costs translate into lower premiums for the FEHBP, the federal government, and its employees. In our survey of FEHBP carriers, we asked carriers how much the FEHBP saved by using directed and non-directed PPOs. Carriers reported substantial savings (See Exhibit 3). The great majority of the savings were realized under directed PPO arrangements. For the six-month period ending June 30, 1997, six carriers reported gross directed PPO savings totaling $390.5 million. This represents 19.7 percent of premiums for those carriers. For the same period, a different

mix of six carriers reported gross non-directed PPO savings totaling $25.5 million representing 2.2 percent of premiums. We conclude that substantial sums can be saved through directed and non-directed PPO arrangements. In view of the fact that directed PPOs provide for steerage of patients, as would be expected, directed PPO savings are significantly larger than non-directed PPO savings. While non-directed PPO savings are substantially lower than directed PPO savings, in absolute terms, they too are significant and offer additional opportunities to reduce FEHBP costs that should not be overlooked, assuming they can be achieved in an ethical and lawful manner.

B. No Evidence Found to Confirm the Use of Payment Schemes that Victimize Health Care Providers in the FEHBP.

Based on our test of insurance benefits paid in August 1997 by FEHBP carriers, we found no evidence that "silent PPOs" were used as a method of capturing discounts or that providers were [*23] being otherwise victimized.

The Committee on Government Reform and Oversight has expressed the concern that medical providers are perhaps being victimized by an alleged practice which accesses provider discounts using subterfuge or misrepresentation. As explained previously, this practice involves the selling of provider names, and the discounts they provide to their directed PPO clients, to third parties who access the discounts by misrepresenting their subscribers as members of the provider's directed PPO. This report uses the term "silent PPO" to describe this practice. In these cases, there is no contractual relationship between the payer of insurance benefits (or their

subcontractors) and the medical providers who are providing the medical services to the payer's subscribers. Such misrepresentation, in our opinion, would constitute, at the very least, an unethical practice in the FEHBP. OPM regulations set forth the minimum standards for health benefit carriers. The standards provide that carriers must perform the contract in accordance with prudent business practices which include, "Legal and ethical business and health care practices." (48 CFR 1609.70(b)(2)). Failure to adhere to minimum standards could be cause for terminating a carrier contract. Consequently, the principal focus of our review was to determine whether any FEHBP carriers, or their subcontractors on behalf of FEHBP carriers, participated in the above described practice.

As explained in the background section, the terms "non-directed PPO" and "silent PPO" have been used interchangeably. Therefore, it was generally thought that those vendors who offer non-directed PPOs also made use of "silent PPOs." Consequently, to search for the use of silent PPOs in the FEHBP, we focused our attention on the vendors who subcontract with FEHBP carriers to provide non-directed PPO services. As a result, we identified five FEHBP carriers who contracted with four (as a result of an acquisition, to become three) vendors to provide non-directed PPO services (See Exhibit 2). [Note: These same vendors may also provide directed PPO services to other clients.] We sampled and reviewed 600 claim lines representing 120 claim lines for each carrier that were repriced by these vendors. The purpose of our sample was to determine whether the discount taken on each claim was pursuant to the medical providers membership in the non-directed PPO and was otherwise consistent with

their contract. We found that in each instance, a series of contractual agreements were in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through their vendors used "silent PPOs" to access discounts.

C. With Minor Exception, Discounts Were Accessed in Accordance with Contract Terms

In addition to ensuring that there was a contractual relationship between all the parties who participated in arranging for the discounts from non-directed PPOs, we also verified that discounts taken were consistent with the contract terms. While the great majority of the claim lines tested were processed in accordance with contract terms, we observed in a few instances, that the FEHBP carrier was not entitled to the discounts taken. We found that the vendors accessed provider discounts in 8 of the 600 claim lines (or 1.3%) that were inconsistent with [*24] contract terms. These improperly taken discounts totaled $675.27 representing 1.24 percent of the $54,370 of discounts taken in our August 1997 sample of 600 claim lines. If our findings for the month of August 1997, were representative of the six-month period ending June 30, 1997, then out of carrier reported non-directed PPO savings of $25.4 million, about $315 thousand was improperly taken. In each case, to access the discount, the contract between either the vendor and provider network or between the provider network and the provider required the steerage of the patient to the provider through some form of financial incentive. In each case, the patient was not steered to the provider in

accordance with the contract terms. Our review at each vendor is further discussed below:

National Preferred Providers Network (NPPN), Inc.

The NPPN is located in Middletown, New York and offers provider networks to its clients. Its network consists of 3,000 hospitals, 18,000 ancillary facilities, and 280,000 physicians. The NPPN contracts with the National Association of Letter Carriers Health Benefit Plan (NALC) to provide a non-directed PPO network. Their agreement provides that NALC is under no obligation to notify participants of the availability of NPPN's network providers.

During our review of the NPPN claim line sample (60 claim lines out of a universe of 33,848), we determined that there were contractual agreements in place that made the medical providers members of NPPN's network. However, we found that NPPN extended some discounts to NALC that we determined were improper. NPPN's contract with one provider network required steerage in order for the discounts to be given to the insurance carrier. This contract covered three claim lines or 5 percent of the claim lines reviewed in our NPPN sample (See Exhibit 4). For the three claim lines, $55.77 in discounts were taken.

Multiplan

Multiplan is located in New York, New York. It is a facility-based preferred provider organization with a network of over 30,000 hospitals and other facilities located throughout the United States. Multiplan contracts with the NALC to provide a non-directed PPO network. Multiplan also provides di-

rected PPO services to other clients. (See appendix for Multiplan comments.)

During our review of the Multiplan claim line sample (30 claim lines out of 6,081), we determined that there were contractual agreements in place that made the medical providers members of Multiplan's network. Generally, we also found that Multiplan agreements with provider networks did not require the steerage of patients, but instead required Multiplan to use its best efforts to encourage appropriate incentives to the Providers. However, we found that Multiplan extended an immaterial discount to NALC from one provider network that we determined was improper (See Exhibit 4). Multiplan's contract with one network required steerage in order for the discounts to be given to the insurance carrier. The contract covered one claim line or 3.33 percent of the lines reviewed. The discount totaled $1.87.

[*25] *United Payors & United Providers (UP & UP)*

The UP & UP is located in Rockville, Maryland. UP & UP provides non-directed PPO services to the following five FEHBP carriers: Foreign Service, APWU, NALC, Rural Carriers, and SAMBA. In September 1997, UP & UP acquired America's Health Plan, Inc.. AHP previously provided non-directed PPO services to FEHBP carriers. (See appendix for UP & UP comments.)

During our review of the UP & UP claim line sample (510 claim lines out of 40,704), we determined that there were contractual agreements in place that made the medical providers members of UP & UP's network. We observed that UP & UP periodically provides its provider networks with a list of client payers. They also provide their hospitals

with a cash prepayment. We also noted that UP & UP agreements state that it will use its best efforts to require each payer client to create financial incentives for covered persons to utilize their providers.

Our review disclosed that UP & UP accessed discounts for four APWU claims that we determined were improper (See Exhibit 4). For the four APWU claim lines, one contract between a provider network and its providers required steerage of subscribers through financial incentives in order for the discounts to be given to the insurance carrier. In all four cases, the carrier did not provide the financial incentives required by the contract. In three of the four cases, the APWU paid 100 percent of the claim. Had co-insurance been applicable to these specific claims, the cost sharing provision of UP & UP's contract with its providers would have been operative thereby authorizing the discounts taken. These four claim lines represent less than one percent of the claim lines reviewed in our sample. The discounts taken total $617.63.

Conclusion

While we found no evidence that silent PPO's were a problem in the FEHBP, we noted that in eight instances, FEHBP carriers were given access to discounts by their vendors to which they were not entitled. In these instances, the contracts with either the provider networks or the providers required a financial incentive to steer patients to the provider's facilities and the subscribers were not so steered. We believe it is the obligation of the vendor to ensure that it does not give FEHBP carriers access to discounts to which they are not entitled. To the extent that these circumstances exist, providers would have

cause for concern. However, the number of instances in our sample were not material.

While the evidence of our review suggests little cause for concern, this conclusion is inconsistent with the level of concern expressed by the medical community. While we found that in the great majority of the cases, discounts taken were consistent with the contract terms, the complex environment and sometimes vague contract terms under which PPOs operate leave expectations on the part of providers that perhaps are not being fulfilled. First, we observed that many of the vendor contracts with provider networks and providers state that the vendor will make a reasonable or best effort to encourage payers to provide incentives to its subscribers to use the vendor's providers. Best efforts do not always translate into actual steerage. Second, the **[*26]** contractual relationship between the vendor and the provider sometimes also involves an intermediary, a regional provider network. These regional network agreements insulate the provider from the true nature of the agreement that exist between the regional networks and the vendor. Third, some payer clients use the vendors for directed PPO services and thus share the same providers with other payer clients who use the vendor's non-directed PPO services. Since the vendor may have only a single contractual agreement with the provider, some of the patients are steered and others are not. Thus, we can visualize how these three factors can combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage. We would suggest that the best solution to these factors is education within the industry. We have observed that both the American Medical Asso-

ciation and the American Hospital Association have already begun such an effort.

D. Use of Non-directed PPOs Encouraged by Appropriation Committees

Our review determined that language in OPM's annual carrier call letters, which encouraged carriers to seek discounts on providers' bills, was a result of discussions between House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

Each spring, OPM issues its annual carrier call letter to health benefits carriers. The call letter is a solicitation to current FEHBP carriers for proposed rate and benefit changes for the upcoming contract year which begins January 1. The letter generally provides overall direction and sets the parameters for acceptable rate and benefit changes. Recognizing that in the market place, price concessions were available from non-network providers (meaning providers who do not belong to directed PPO networks), the March 1993 call letter for the 1994 contract year included a new provision which encouraged carriers to obtain price concessions from providers including non-PPO providers (again meaning providers who do not belong to directed PPO networks). The provision read as follows:

> "Carriers are to actively establish or promote the expansion of existing PPO arrangements in terms of availability to enrollees as well as coverage provided. In addition, OPM is aware that price concessions are available from non-network providers, e.g. hospitals, so carriers are expected to obtain the lowest price available for all goods and services, in-

cluding non-PPO providers." (Underline added)

A similar provision was included in the March 1994 call letter for contract year 1995. It read as follows:

> "We continue to encourage expansion of PPO arrangements, in terms of availability of PPO providers to enrollees and coverage provided. In addition, carriers are expected to obtain the lowest price available for all goods and [*27] services, including those of non-PPO providers. All carriers must put in place procedures to capture discounts from all bills presented and/or contract with vendors to do this." (Underline added)

The call letters for contract years 1996, 1997, and 1998 continued to encourage carriers to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. In addition, they each contained the following pertinent provision:

> "We also expect carriers to put in place procedures to capture discounts from bills presented, where cost effective to do so."

The committee was concerned that the call letter language may have encouraged, perhaps inadvertently, the use of improper payment discounts. By "improper," they meant any system of payment discounts for payers who are not entitled to such discounts. They believed that the result of any such improper discount would be to cause an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give. The committee was also concerned that the call letter seems to have had the

effect--intended or not—of spawning efforts on the part of some network managers and/or brokers to require the use of non-directed PPOs by statute. As a consequence, the committee asked us to determine what prompted the language in the OPM call letter.

The former Associate Director for Retirement and Insurance recollected that in 1993 the House Appropriation Committee was considering either report or statutory language which would require FEHBP carriers to take advantage of provider discounts available in the market place. The former Associate Director indicated that he opposed any language which would regulate the market place. Consequently, as a compromise he agreed to include language in OPM's call letter which would encourage FEHBP carriers to take advantage of whatever discount arrangements were available in the market place. In 1993 (for the FY 1994 appropriation) and again in 1994 (for the FY 1995 appropriation), both the House and Senate Appropriation Committee reports on OPM's appropriation bill applauded OPM's action. The House report for the FY 1994 appropriation stated:

> "The Committee feels that, in addition to the cost savings obtained by HMO's and PPO's, all FEHBP carriers should endeavor to obtain the lowest price available for the goods and services they provide. The Committee has learned that while price concessions are available from most providers, not all FEHBP carriers are receiving such discounts. Many carriers in the FEHBP merely pay the billed charges or the usual and customary rate.

> The Committee is aware, however, that some carriers are utilizing large discount networks that have negotiated more favorable rates with providers. The Committee feels there could be significant savings realized through a more concerted effort by carriers to pay the lowest price available for billed medical [*28] charges, and applauds the Office of Personnel Management's reference to such potential efforts in its Letter to Carriers dated March 31, 1993. The Committee believes these efforts should in no way disrupt benefits or attempt to direct patients if they choose not to be directed to specific providers."

Based on our interview with the former Associate Director for Retirement and Insurance and our review of the Appropriation Committees' Report for the Treasury, Postal Service, and General Government Appropriation bills for 1994 through 1995, we conclude that the call letter language was prompted by the House Appropriation Committee.

IV. OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to determine whether FEHBP carriers were taking advantage of health care providers by using payment schemes that create payment discounts for payers who are not entitled to them. In performing our review, the committee staff requested that we also:

1. Identify organizations that contract with FEHBP carriers to reprice provider bills to obtain a discount where the FEHBP carrier does not have a directed PPO with the provider or the patient has not been given a financial incentive

to use the provider from whom the discount was obtained.

2. Determine whether any discounts were taken by FEHBP carriers to which they were not contractually entitled.

3. Identify providers that have a contract with vendors based solely on the possibility of becoming a part of that vendors network.

4. Identify providers that have a contract with a vendor based solely on the concern that they need to do this to remain competitive.

5. Determine what prompted the language in the OPM call letter to encourage the use of non-directed PPOs by FEHBP carriers.

Our review was performed in accordance with generally accepted government auditing standards for performance audits. The review was performed at the Government Employees Hospital Association, Kansas City, Missouri; United Payors and United Providers, Rockville, Maryland; Multiplan, New York, New York; and National Preferred Providers Network, Middletown, New York during the period June 1997 through December 1997. Additional work was performed in our offices in Washington DC. Our review entailed the following review procedures:

- We conducted an initial review at the FEHBP's Government Employees Hospital Association (GEHA) plan to gain an understanding of the subject. We interviewed carrier officials and traced 34 claims, which were repriced by non-directed PPO vendors, [*29] to contractual

agreements between the GEHA, vendors, and providers. We found no evidence of questionable conduct or contract inconsistencies; that is, in each case, we found that contracts were in place and that discounts were taken pursuant to the contract terms.

- We surveyed 9 of 14 FEHBP fee-for-service carriers to identify which carriers used directed and non-directed PPOs and to identify the non-directed PPO vendors used by the carriers. We did not survey: Blue Cross Blue Shield (has its own PPO networks), GEHA (covered in survey work), Association Benefit Plan (requires extraordinary security procedures), Panama Canal Area Benefit Plan (out of country), and Secret Service (underwritten by BCBS who has its own PPO networks).
- Of the nine carriers surveyed, we found that five carriers used non-directed PPO arrangements. They were:

    1. American Foreign Service Protective Association (Foreign Service),
    2. American Postal Workers Union Health Plan (APWU),
    3. National Association of Letter Carriers Health Benefit Plan (NALC),
    4. Rural Carriers Benefit Plan (Rural Carriers), and
    5. Special Agents Mutual Benefit Association (SAMBA).

We identified four vendors that provided non-directed PPO services to the five carriers (See Exhibit 2). They were:

1. United Payors and United Providers (Up & Up), Rockville, Maryland,
2. America's Health Plan (AHP), Rockville, Maryland (Acquired by UP & UP),
3. Multiplan, New York, New York, and
4. National Preferred Provider Network (NPPN), Middletown, New York.

- From each carrier, we acquired a computer tape of all benefit payments during August 1997. From these tapes, we extracted 80,633 claim lines representing $2.7 million in discounts paid by the five carriers and repriced by one of the four non-directed PPO vendors.
- From the extracted claim lines, we sampled 600 claim lines (120 per carrier) representing $54 thousand in discounts.
- For each of the 600 claim lines, we reviewed the carrier's Explanation of Benefits, when available, traced claims to carrier contracts with vendors and further traced claims to vendor contracts with provider networks and/or providers.
- We reviewed the carrier and provider network contracts at the vendors' offices to determine whether contracts were in place and to determine whether the contracts [*30] required steerage in order to access the discounts. When present in the vendors file, we also examined the provider network's contracts with providers to determine whether steerage was required.
- We recalculated a sample of discounts to verify that discounts were calculated consistent with contract terms.

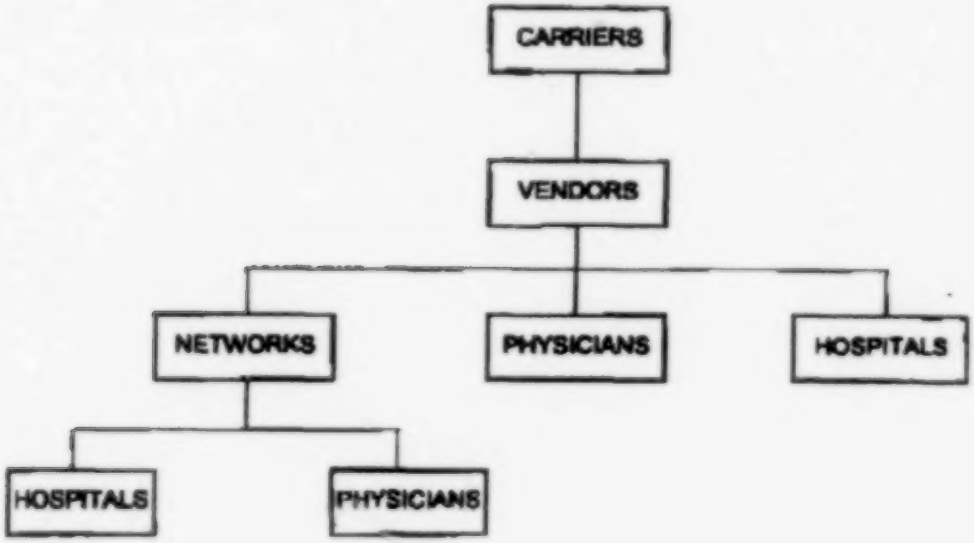
- We met with representatives from the American Medical Association and the Federation of American Health Systems.
- We did a literature search and reviewed the articles identified.
- We surveyed 30 hospitals that complained to OPM about its call letter provision regarding the capture of discounts.
- With regard to the call letter issue, we reviewed OPM's call letter files for the period 1991 through 1997 and interviewed both the former Deputy and Associate Directors for Retirement and Insurance Services to determine who or what influenced OPM to include in its annual call letter a statement which would encourage carriers to capture discounts from non-PPO medical providers. We also reviewed the House and Senate Appropriation Committee Reports for the Treasury, Postal Service, and General Government Appropriation bills for 1993 through 1995.

Due to time constraints, we were not able to perform sufficient procedures to identify health care providers that entered into a non-directed PPO contract arrangement with a vendor based solely on the possibility of becoming a part of that vendor's directed PPO network or to remain competitive. While we did make some limited inquires, those inquires were insufficient to either confirm or deny whether these were substantive reasons for entering into a non-directed PPO arrangement.

[*31]

EXHIBIT 1

FLOW OF DISCOUNT ARRANGEMENTS



[*32]

EXHIBIT 2

PREFERRED PROVIDER ORGANIZATIONS

Employee Organization	Multi-plan, Inc.	National Preferred Provider Network	United Payors & United Providers and America's Health Plan
American Foreign Service Protective Association			✓
American Postal Workers Union Health Plan			✓
National Association of Letter Carriers Health Benefit Plan	✓	✓	✓
Rural Carrier Benefit Plan			✓
Special Agents Mutual Benefit Association			✓

Vendors:

Multiplan, Inc.
115 Fifth Avenue
New York, NY 10003
Phone: (212) 780-2000

National Preferred Providers Network, Inc.
407 East Main Street
Middleton, NY 10940
Phone: (914) 343-1600

United Payor and United Providers/America's Health Plan
2275 Research Boulevard, Sixth Floor
Rockville, MD 20850
Phone: (301) 548-1000

[*33]

EXHIBIT 3

PREFERRED PROVIDER ORGANIZATIONS REVIEW
PREMIUM PAYMENTS
FOR PERIOD ENDING JUNE 30, 1997
(UNAUDITED)

DIRECT PPOs

CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
APWU	203,027,700	29,825,317	14.69%
GEHA	477,451,392	106,799,463	22.37%
MHBP	903,996,936	179,148,767	19.82%
NALC	323,256,494	58,873,579	18.21%
POST-MASTER	29,373,621	5,007,328	17.05%
SAMBA	41,255,807	10,839,047	26.27%
Gross	1,978,361,950	390,493,501	19.74%
Fees	29,854,245	29,854,245	
Net	1,978,361,950	*360,639,256	18.23%

NONDIRECT PPOs			
CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
AFSPA	18,858,169	392,495	2.08%
APWU	203,027,700	2970380	1.46%
GEHA	477,451,392	7573843	1.59%
NALC	323,256,494	12,573,249	3.89%
RURAL	85,536,527	1,630,669	1.91%
SAMBA	41,255,807	311,073	0.75%
Gross	1,149,386,089	25,451,709	2.21%
Fees		4,345,450	
Net	1,149,386,089	21,106,259	1.84%

* Amounts saved may be further reduced as a result of financial incentives given to subscribers.

EXHIBIT 4

Vendors	Arrang-ement between Vendor/ Network	Arrang-ement between Net-work/ Provider	Total Number of Errors	Total Amount of Sample Errors
National Preferred Provider Network	3		3	$55.77
Multiplan	1		1	$1.87
United Payors & United Providers		4	4	$617.63
Total Errors	4	4	8	$675.27
Number of claim lines reviewed			600	$54,370
Error Rate			1.3%	1.24%

APPENDIX

SIGNIFICANT RESPONSES FROM AFFECTED PARTIES

1. William E. Flynn, III, Associate Director for Retirement and Insurance, Office of Personnel Management
2. Richard G. Miles, President, Government Employees Hospital Association, Inc.
3. Carroll Midgett, Chief Operating Manager, Health Plan Department, American Postal Workers Union, AFL-CIO
4. Calvin Engel, Assistant Administrator, National Association of Letter Carriers Health Benefit Plan
5. S. Joseph Bruno, Chief Financial Officer, United Payors & United Providers
6. Sidney L. Meyer, Executive Vice President, MultiPlan



United States
Office of
Personnel Management

Washington, D.C. 20415

MEMORANDUM FOR PATRICK E. MCFARLAND
INSPECTOR GENERAL

FROM: WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR
FOR RETIREMENT AND INSURANCE

Subject: Silent PPOs, Report Number 99-00-97-054

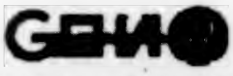
Thank you for sharing your "Report on the Use of Silent PPOs in the Federal Employees Health Benefits Program" with us. We were impressed with the rigor and thoroughness of the report and are gratified that it confirmed our belief that the carriers which contract with us engage in lawful and ethical practices in obtaining discounts from health care providers.

We were pleased that the small number, only 1.3 percent, of discounts that occurred in a manner inconsistent with agreed upon contract terms were inadvertent errors which were neither material nor indicative of any systemic problem in need of correction. While much concern has been expressed about "silent PPOs" which take inappropriate discounts from health care providers, your report definitively shows that if "silent PPOs" exist at all, they clearly do not exist in the Federal Employees Health Benefits Program. What do exist are legitimate non-directed PPOs which produce material savings for the carriers that employ them. While these savings do not approach those obtained by the same carriers from their directed PPO networks, they still consti-

tute savings which would not otherwise have been achieved.

We hope that your report will put to rest the need that some parties have expressed for action on our part to address a "silent PPO" problem that does not exist.

[*37]



The Health Plan for Federal Employees

February 16, 1998

Office of the Inspector General
Office of Personnel Management
Attention: Sanders Gerson
Room 6400
1900 E St. N.W..
Washington, D.C. 20415

Subject: Draft Copy of Report on Silent PPOs

Dear Mr. Gerson:

I have reviewed the report and was relieved to see that the conclusions supported our position on this matter. As a matter of editorial comment only I have a couple of observations from reading the report.

The report discusses the concept of an "ideal" PPO. I believe that the term "ideal" used in this context is too subjective and creates the impression that one type of network is better than another. In reality, what may be desired by a provider may not be ideal from a payor standpoint or from that of another provider.

Although many PPOs do provide services related to controlling utilization this is not universal and the

savings derived from utilization controls is minor in comparison to the savings from contractual agreements with providers. In my opinion, whether or not a PPO provides utilization controls is not relevant to the subject matter. I might also suggest that you substitute "traditional" for "ideal" to describe directed networks in the second paragraph on page 2.

I thought the report language could be strengthened to note that although a small number of errors were detected there did not appear to be a systematic practice of deception nor were any of the errors made or a material nature.

[*38] Overall, I was very pleased with conclusions reached and am hopeful that this report will put the issue to rest so we can all devote our efforts to more substantive topics. Thank you for giving me the opportunity to review the draft report and to provide comment.

Sincerely,

s/

Richard G. Miles
President



Health Plan Department
American Postal Workers Union, AFL-CIO
P.O. Box 420, Baltimore MD 21203

February 17, 1998

Mr. Sanders P. Gerson
Deputy Assistant Inspector General for Audits
Office of Personnel Management
1900 E. Street NW – Room 6400
Washington, D.C. 20415

Dear Mr. Gerson:

We appreciate the opportunity to comment on the Office of Inspector General's report on "Silent PPOs" before its release to the House Committee on Government Reform and Oversight.

Based on a review of the draft report dated February 6, 1998 and discussions with the OIG audit staff, it is our understanding that the four APWU claim lines in question (out of 120 claims reviewed) involved agreements between the hospitals and a network which required steerage of subscribers through financial incentives in order for the discounts to be given. While the contract between APWUHP and UP & UP did not require steerage and the contract between Up & Up and the network did not require steerage, the contract between the network and the providers apparently required steerage.

Currently, the APWUHP is working with UP & UP to determine what alternatives are available to eliminate the conflicting language in the provider – network contracts.

Additionally, the 4 claims lines out of 120 claims reviewed represents a 97% processing accuracy rate which is well above the 95% processing accuracy standard set by the Office of Personnel Management.

[*40] If you have any questions regarding the enclosed information, you can reach me at (301) 622-5554.

Cordially.

s/

Carroll Midget,
Chief Operating Manager

NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN

[illegible]

Delivered via Facsimile and
U.S Mail

February 17, 1998

[illegible]

Office of the Inspector General
U.S. Office of Personnel Management
Room 6400
1900 E Street, N.W.
Washington, DC 20415

Attention: Sanders Gerson, Deputy Assistant Inspector General for Audits

Dear Mr. Gerson:

Thank you for the opportunity to review the Office of the Inspector General's (OIG) preliminary report on silent and/or non-directed PPO type programs. As this report indicates, PPO arrangements are defined and applied by FEHBP carriers with differing methodologies. Because of this, it is difficult to draw a parallel between the FEHBP carrier's PPO type applications.

Reviewing this OIG draft suggests that OIG is only releasing aggregate fees (i.e. the amounts paid to PPO contractors for savings on discounted services) for the FEHBP program. The NALC Health Benefit Plan believes that OIG's final release should not disclose individual negotiated fees with any given vendor - being that they are competitively derived. Releasing these fees will violate the Plan's disclosure terms of PPO agreements and may jeopardize our capability to obtain future competitive bidding with PPO and discounted provider groups.

Again, thank you for giving the NALC Health Benefit Plan an opportunity to review and comment on this report before its final release.

Sincerely,

s/

Calvin Engel
Assistant Administrator

February 17, 1998

Sanders P. Gerson
Deputy Assistant Inspector General for Audits
U.S. Office of Personnel Management
Office of Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415

Dear Mr. Gerson:

Thank you for the opportunity to meet with you and Mr. Gibbons on Friday afternoon regarding the results of the Office of the Inspector General's Review ("OIG Review") of the use of Preferred Provider Organizations ("PPOs") in the Federal Employees Health Benefit Program ("FEHBP"). We, the management team at United Payors & United Providers, Inc. ("UP&UP"), want to reiterate to the OIG that:

(1) The review was performed in a professional and efficient manner with knowledgeable staff.

(2) The OIG's extension of their FEHBP Review to include PPO provider contracts was an important element of examining the benefits derived by the FEHBP. The Review validated the importance of the PPO networks in obtaining savings for not only the FEHBP but also for the individual plan members.

(3) The OIG's Review was an important step in determining that there was "no evidence found to confirm the use of payment schemes that victimize health care providers in the

FEHBP". Further, we appreciated your comments at our meeting which indicated that a reader of your Review report should determine that (a) there was no evidence of "Silent PPO" activity, (b) the FEHBP derived significant benefits from PPOs, and (c) there is no need for further audit work by the OIG or any other oversight body regarding the use of PPOs.

We believe that if the FEHBP were to be subjected to a further review, it would be imperative for the OIG, or other agency of the Federal Government, to audit all vendors (so-called Directed and non-Directed PPOs) that provide financial intermediary services between FEHBP payors and health care providers. These intermediaries (PPOs) offer identical products that are utilized by the commercial payor community (i.e., major insurance companies). From our perspective, it is important to note that discounts enjoyed by the FEHBP through so-called Directed PPO products are also supported by a similar [*43] commercial contracts. In fact, if such Directed PPO arrangements were not supported by a valid contract, there would be evidence of a "Silent PPO" and an abusive provider relationship. Specifically, we believe that all other so-called Directed PPOs should be subjected to the same contractual scrutiny that other FEHBP financial intermediaries have experienced. To drive this point home, if there is a need to expand your Review, we believe it should be expanded to the other PPOs serving the FEHBP.

Audit/Review Conclusions Should Be Clearly Stated

We are pleased with the results of your Review and we recommend that your report consist of an opinion paragraph (presented on page 1 of your report) that

indicates the scope of your Review and the results obtained as noted in your headline comments A and B on page 6 of your draft report. The substantial background information section of your report inadvertently allows the reader to believe that unverified industry data and processes represent the results of your Review. Specifically, we believe that there is no support for the following health care terminology used in your Report:

- Financial incentives
- Ideal PPO
- Steerage
- Directed PPO
- Non-Directed PPO

If the reader of your Review report requires background information, we suggest an appropriate Appendix which describes how the $1 trillion health care industry operates including the Blue Cross and other so-called Directed PPOs. This write-up should also include common health care terminology and not "hearsay" comments which you describe as anecdotal information from the Committee staff and other special interest groups.

UP&UP is a public company required to make disclosures to the Securities and Exchange Commission, therefore, we are confident that our business would be characterized using the following informational points:

- ✓ UP&UP's clients include all major insurance carriers — Aetna, Cigna, John Hancock, United Healthcare, Prudential, Mutual of Omaha, etc. These clients use the same national health care network as the FEHBP.

- ✓ UP&UP is a financial services company that supports the health care industry. Insurance companies and other major payors design health plans for a full range of large and small group employers, unions and other Government employees that utilize the UP&UP network.
- ✓ UP&UP regularly communicates with its provider clients by describing how the beneficiaries of our payor clients use the provider network. [*44]
- ✓ UP&UP's contracts with its providers offer tangible benefits such as a prepayment of one month (1/12) of medical claims represented by all of UP&UP's payor clients. As of December 31, 1997, UP&UP has prepaid approximately $17 million in medical claims.
- ✓ UP&UP has contracted with hospitals, ancillary facilities and physicians that represent "high utilization" providers of the beneficiaries that are covered by the health plans of UP&UP's payor clients.
- ✓ UP&UP's national network product is based on certain principles:
  - UP&UP does not assume underwriting risk
  - UP&UP prepayments to providers do not require the provider to assume business risk (capitated payments do shift risk to the provider)
  - UP&UP facilitates the continued use of the health care provider by the beneficiary through positive communication (directories, 800 numbers, ID cards). "Steerage"

to hospitals is done by physicians and UP&UP believes that it is inappropriate to interfere with the doctor-patient relationship.

✓ The UP&UP network savings are <u>always</u> shared with the beneficiary. UP&UP believes that the waiver of a "co-payment" is a financial technique that is negative for the following reasons:

- Interference with the patient's relationship with their physician.
- Increase in health care costs, i.e.:

	UP&UP Relationship	Co-Payment Waiver Financial Technique
Hospital Bill	$1,000	$1,000
Contractual Allowance	(200)	(200)
Net Billing	800	800
Co-Payment Waiver (20%)	N/A	160
Total Health Care Cost to Payor (80/20 plans)	640	800
Increase Health Care Cost Shifting		20%

Further, as noted above, we believe that when a co-payment waiver is required to "so-called direct" a patient to a specific hospital, the FEHBP actually incurs a significant cost in addition to the PPO network access fee in order to achieve "steerage" (if one actually believes that anyone or anything steers a patient other than a physician).

[*45] Full Disclosure of Background Information is Needed to Make the OIG Report Complete

There are references to Chairman Mica, House Subcommittee on Civil Service, in your report. We believe that it would be important background information for Congressman Mica's comments on October 22, 1997 to be included in your report. An excerpt of his comments are:

> "The second major revision in the amendment deals with the most controversial matter in the bill: the question of 'silent PPOs'. Everyone acknowledges that Preferred Provider Organizations (PPOs) play an important role in today's health care market. Frequently, these PPOs negotiate discounted rate schedules with health care providers in exchange for certain incentives. The incentives may include an agreement to steer patients to the provider, in the case of so-called "directed PPOs', or they may include financial incentives such as prepayment or prompt payment in the case of so-called 'non-directed PPOs'. Both directed and non-directed PPOs provide legitimate and valuable benefits to health care providers, carriers, and patients.
>
> However, many believed that the original language placed non-directed PPOs at a

competitive disadvantage. That was not Chairman Burton's intent, and it is certainly not the intent of this subcommittee.

Silent PPOs', however, are another matter. These organizations take advantage of health care providers by arranging for a carrier to obtain access to discounted rates it is not entitled to. The first victims of this practice are the Doctors and Hospitals. But in the end, all of us will pay the price as the losses incurred by these providers are shifted to other consumers of medical services."

Also, an October 16, 1997 letter to John Mica from Constance A. Morella, M.C., Thomas M. Davis, M.C., Elijah E. Cummings, M.C. and Harold E. Ford, Jr., M.C. indicated that:

"We are writing to express our collective concerns about Section 5 of H.R. 1836. Currently, fee-for-service plans in the Federal Employees Health Benefits Program (FEHBP) are saving the government millions of dollars a year through their utilization of various savings initiatives, including non-directed efforts. Section 5 of H.R. 1836 would cost the FEHBP these savings and create an administrative burden that would increase administrative costs.

We are concerned about these increased costs to FEHBP, which would be borne jointly by the federal government and federal employees. Already, next year's premiums are rising, on average, by 8.5%. Increased costs caused by this legislation would almost certainly need to be addressed in both authoriz-

ing and appropriating legislation if Section 5 is enacted. The Office of Personnel Management (OPM) and carriers within the program have expressed concern over these additional costs. In the Congressional Budget Office's (CBO) first approximation, FEHB costs could increase by between $10 and $50 million a year after 1998 if Section 5 of H.R. 1836 were enacted. The governments share would be approximately 70 percent of that amount, split roughly equally between additional agency costs and government payments for annuitants.

Section 5 would legislate a mandate on the FEHBP, instead of leaving these issues to the marketplace to sort out. Our job is to protect the federal treasury and federal employees — not to become involved in private sector disputes."

[*46] Finally, you indicated during a telephone conversation with UP&UP that Congresswoman Morella had asked the OIG a series of questions concerning your Review and the scope of your work. We believe that the entire OIG response to Congresswoman Morella would represent important background data as an Appendix to your report.

Hearsay, Anecdotal Comments and Unsubstantiated Data Do Not Constitute a "Review Opinion"

We previously noted that your background data could easily be confused by a reader of your report to be the results of your Review. We reinforce our comments on the efficiency and effectiveness of your Review and we believe that your "Review Opinion" included in the second paragraph of page 7 of your

report should be on page 1, paragraph 1 of your report. Your opinion includes these important factual statements:

> "Our purpose was to determine whether the discount taken on each claim was pursuant to the medical providers membership in a non-directed PPO and was otherwise consistent with their contract. We found that in each instance, a series of contractual agreements was in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through its vendors used silent PPOs to access discounts."

The conclusion section of your report includes many industry statements that may not be universally accepted, terms without an appropriate definition and a conclusion sentence that is inconsistent with your Review opinion on page 7, paragraph 2. Specifically, your conclusion in the first paragraph on page 10 states:

> "Thus, these three factors combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage."

The word "confusion" has a negative connotation. Of course a $1 trillion industry has "complex" elements. The providers in question are organizations with billions of dollars in revenue, sophisticated financial staffs and legal counsel representation. It is difficult

to believe that they do not understand contractual relationships entered into.

Specific Comments Concerning UP&UP's Review Items

With respect to the four UP&UP "errors" as presented in Exhibit 4, we believe that three of the four items noted are ad errors. Our support is as follows:

Monongalia General Hospital

This contract states on page 4, section 3.4, the following regarding incentives: [*47]

> "HPO will offer most favorable terms to payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network. All HPO Network payors provide financial incentives for covered subscribers that utilize the network. Financial incentives range from shared saving arrangements, to reduced or waived co-insurance/deductibles, to benefit differentials and planned design."

This section addresses two items:

(a) Most favorable terms to payors, and
(b) Financial incentives for covered subscribers.

Item (a) refers to offering the payor client a lower fee if they provide greatest incentives to their covered subscribers; while item (b) refers to financial incentives for covered beneficiaries. The contract specifically defines the range of financial incentives from "shared savings to benefit differentials". Our Payor clients utilize "shared savings" to meet the financial incentive contract requirement, **therefore, this does not constitute an "error"**.

Baptist Hospital of East Tennessee (page 4, section 3.4)
East Jefferson General Hospital (page 4, section 3.2)

These contracts state the following regarding incentives:

> "HPO will offer most favorable terms to Payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network."

The respective sections address "most favorable terms to Payors" and refers to offering the Payor client a lower fee if the Payor provides greatest incentives to their covered subscribers. There are no contractual requirements regarding financial incentives for covered subscribers, therefore this does not constitute an "error". Notwithstanding this, all our Payor clients utilize the "shared savings" financial incentive program for their covered subscribers. If the Payor client implements additional methods of financial incentives such as waived co-insurance and deductibles, benefit differentials, etc., then the fee paid by the payor client to access the network would be reduced.

Specific Comments Regarding Exhibit 3

As currently presented, Exhibit 3 does accomplish the objective stated at our meeting to "demonstrate that utilization of both Directed and non-Directed PPOs benefit the FEHBP program". However, the method in which the information is presented, and certain elements of the information, are unclear, inaccurate and misleading. The unclear, inaccurate and misleading elements are as follows:

(a) Net Direct PPO savings do not reflect the "actual" additional cost to the FEHBP of the

financial incentives (reduction or waiver of co-payments/ deductibles, etc.); and [*48]

(b) Non-Directed PPOs' savings ratio calculations are misleading. Specifically, the amount of premium payment is significantly overstated due to the fact that the premium payment must be reduced by the actual amount applicable to Directed PPOs to avoid double counting.

We have revised Exhibit 3 to reflect a clearer presentation of the data and it is included as an attachment to this letter for your consideration. We believe the revised Exhibit 3 reflects your stated objective "to demonstrate that utilization of both Directed and Non-Directed PPOs benefit the FEHBP program".

******

In closing, we apologize if the tone of our comments indicate any displeasure with the Review process by the OIG. In fact, we are pleased that the matter seems to be resolved since your Review indicated that there was no evidence of any "Silent PPO" activity. As a public company, we are sensitive about comments made concerning our business. We operate with strong business principles and our national health care network is used to process approximately $3 billion of medical claims for all major insurance carriers. As a public company, we know we are subject to public scrutiny and we are satisfied with the results of your Review. We do not believe, however, that government oversight should extend into a matter that is clearly governed by contractual relationships.

Thank you again for allowing us to comment on your draft Review report. Of course, we would be pleased

if our response (or portions of our response) is included as an Appendix to your final report as background information on the health care industry.

Very truly yours,

s/

S. Joseph Bruno
Chief Financial Officer

SJB/alw
Attachment

[*49] PRELIMINARY REPORT: FOR DISCUSSION PURPOSES ONLY
NOT FOR PUBLIC RELEASE

EXHIBIT 3
(revised)

PREFERRED PROVIDER ORGANIZATIONS REVIEW

PREMIUM PAYMENTS
FOR PERIOD ENDING JUNE 30, 1997

Carrier	Premium Payments	Net Savings	Ratio
APWU	$203,207,700		
GEHA	477,451,392		
MHBP	903,996,936		
POST-MASTER	29,373,621		

SAMBA	41,255,807		
AFSPA	18,858,169		
NALC	323,256,494		
RURAL	85,536,527		
Total	$2,082,936,646		
Net direct PPO savings (1)		$360,639,256	17%
Net non-direct PPO savings		21,106,259	1%
Total		$381,745,515	18%

(1) Directed PPO's by definition must utilize a direction mechanism in the form of financial incentives (reduction or waiver of co-payments and/or deductibles for the federal employee). These financial incentives are not included in this analysis as they were not available from the FEHBP Carriers. The impact of these financial incentives would be to reduce net savings since the FEHBP paid a larger portion of the premium payments (i.e., the reduction or waiver of the co-payments or deductible for the federal employee is borne by the FEHBP Carriers).



Sidney L. Meyer
Executive Vice President

February 19, 1998
Via Fax: 202-418-0630

United Stated Office of Personnel Management
Office of the Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415
Attention: Sanders P. Gerson

Deputy Assistant Inspector General for Audits

Re: **Silent PPO Review**

Dear Mr. Gerson:

I am writing on behalf of MultiPlan, Inc., in response to the draft, preliminary Report (the "Draft Report") that you prepared on completion of your review of the use of "silent" and "non-directed" preferred provider organizations ("PPOs") within the Federal Employees Health Benefits Program ("FEHBP"). We appreciate the OIG's hard work on this complex and sensitive issue and the opportunity to comment on the Draft Report.

As an initial matter, we concur with your view that giving health payers access to provider discounts through subterfuge or misrepresentation would constitute, at the very least, an unethical practice in the FEHBP. MultiPlan, Inc. strongly opposes these so-called "silent" PPOs. We also are pleased, but not surprised, that OIG's review has confirmed that Mul-

tiPlan is not a silent PPO and does not engage in such practices. Indeed, OIG's review, which was performed in accordance with generally accepted government auditing standards for performance audits, demonstrates that MultiPlan had written contracts in place in every case reviewed and that all but one of the MultiPlan claims reviewed were processed in accordance with MultiPlan's provider contracts. In the case of that one claim, MultiPlan inadvertently extended a discount to the FEHBP plan of $1.87 -- a trivial error. As this example illustrates, MultiPlan's claim payment accuracy far exceeds the FEHBP's own standard for accuracy of payment. *See* Office of Personnel Management, *Financial Statements Fiscal Year 1996* at *56¬57*.

America's Managed Care Partner

115 Fifth Avenue
New York NY 10003-1004
Tel: (212) 780-2055
Fax: (212) 780-0410

[*51] We therefore ask that you expressly state in the final Report that MultiPlan is not a "silent" PPO and does not engage in "silent" PPO practices, and that all of MultiPlan's claims reviewed were processed under written contract administered in a manner that exceeds FEHBP standards for accuracy of payment

The OIG has conducted a careful and professional review of this matter The Draft Report, however, includes some language that is inconsistent with the OIG's data and conclusions as presented in the Draft Report. It also uses some terms in a manner that is misleading and inaccurate. We ask that you correct

these points, which are described below, in your final Report.

First, on pages 6-7, the Draft Report states that "anecdotal evidence" may justify concern on the part of the Committee on Government Reform and Oversight that medical providers arc perhaps being victimized. This "anecdotal evidence," however, is not disclosed. And, in any event, the OIG's factual investigation refutes this "evidence" and dispels any basis for concern. We urge that this passage be deleted, less it be quoted out of context in support of a conclusion directly contrary to that reached in the OIG's review. For the same reason, the discussion of claims payment should be deleted from section B, on pages 6-7. Rare instances of inaccurate payment under written contracts is a separate topic from "vitalization" of providers under "silent" PPOs, and is fully addressed in section C.

Second, the Draft Report inaccurately implies that surveyed vendor's contracts with network providers are "vague" and create expectations on the part of providers that are not being fulfilled. This unsupported conclusion is in stark contrast to the conclusion regarding contract compliance, which is supported by a detailed claims audit. The report does not cite a single instance in which the OIG concluded that a provider had reason to be confused regarding the terms of its contract with MultiPlan or one of the other vendors or in which a specific provider's reasonable contractual expectations were not met. For these reasons, the Draft Report's discussion regarding allegedly vague contract terms and unmet provider expectations should be deleted.

Third, the Draft Report's use of the terms "directed PPO" and "non-directed PPO" is inaccurate. Multi-

Plan is classified as "non-directed", but MultiPlan does provide varying degrees of direction in its work with FEHBA plans.

[*52] MultiPlan requires, for example, that its clients share with subscribers the savings realized from its provider discounts by calculating the subscriber's coinsurance payment on the basis of the discounted rate. This results in a direct reduction in out-of-pocket expenses or FEHBP subscribers who use MultiPlan network providers. If, as some suggest, financial incentives are essential to a directed PPO arrangement, then MultiPlan meets this definition.

But financial incentive are not the only effective way to steer subscribers to network providers. For example, MultiPlan maintains a web site referred service on the Internet that is so extensive and accessible that it won an award from USA Today. We encourage you to review the site, which is at http://ww.multiplan.com. Similarly, MultiPlan operates a 24-hour-a-day toll-free referral line staffed by nurses, and the FEHBA plans have been notified of this referral line. MultiPlan also offers a transfer assistance program that arranges for patients that are in a non-network hospital to be safely transferred to a network hospital.

Finally, steerage is not the only reason providers agree to extend discounts to MultiPlan, or example, MultiPlan's arrangements result in much better cash flow for network providers. MultiPlan requires its clients to make timely payment to providers and offer pre-audit payments and prepayment programs as a deposit or guarantee for bed days or for specific procedures. These programs provide concrete, financial benefits to MultiPlan's network providers. MultiPlan also provides quality support for network pro-

viders through its rural health care support, credentialing and certification, discount purchasing programs for medical services and supplies, and an extensive library of critical pathways that are shared with all of our network providers. These programs directly benefit our network providers. Equally important, however, they encourage high quality of care for FEHBP subscribers.

For these reasons, we urge you to revise the Draft Report to note that benefit differentials are not the only appropriate form of steerage, and that PPOs such as MultiPlan *do* direct subscribers to providers in their networks. In addition, we ask that the final Report state that steerage is not the only benefit that FEHBP providers can gain from membership in a PPO network.

Fourth, the Draft Report does not scrutinize the practices of entities that operate PPOs that the Draft Report labels "directed." Many of these entities, for example, contract with hospitals for an EPO rate, and/or HMO rates and/or for a PPO rate. The OIG review did not examine whether the directed PPOs accessed the correct rate in accordance with the contract term, to provide a more balanced assessment of whether health care providers are being "victimized" by FEHBP payers -- the stated purpose of the Draft Report -- the OIG's review should be expended to [*53] include the practices of so-called "directed" PPOs. If this is not practical at this time, the report should note a minimum that there is also the potential for abuse by the PPO's that the Draft Report labels "directed," and that the OIG has not reviewed their practices.

Fifth, the Draft Report should note that OPM's 1993 call letter encouraging FEHBP carries to obtain the

lowest price available for all goods and services is entirely consistent with existing legal requirements. *See* C.F.R. § § 1600 *et seq*. OPM obviously did not intend for the carriers to do this through unethical or illegal means.

In summary, Provider discount arrangement with PPO's exist today for a variety of reasons. These reasons include direction of patients, collection and cash flow advocacy and quality support. The depth of discount vary as does the reason for providing them. This is all part of the process that helps keep health care in America self regulated as to price and the world leader as to quality.

Again, we appreciate the opportunity to comment on the Draft Report.

Please call Harvey Sigelbaum or me if you have any questions, or if we can be helpful to you in any way.

Very truly yours,

s/

Sidney L. Meyer
Executive Vice President
Chief Legal and Legislative Affairs Officer

[*54]

VIII. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

* * * * * * *

CHAPTER 59—ALLOWANCES

* * * * * * *

SUBCHAPTER IV—MISCELLANEOUS ALLOWANCES

* * * * * * *

§ 5948. Physicians comparability allowances

(a) Notwithstanding any other provision of law, and in order to recruit and retain highly qualified Government physicians, the head of an agency, subject to the provisions of this section, section 5307, and such regulations as the President or his designee may prescribe, may enter into a service agreement with a Government physician which provides for such physician to complete a specified period of service in such agency in return for an allowance for the duration of such agreement in an amount to be determined by the agency head and specified in the agreement, but not to exceed—

(1) * * *

(2) [$20,000] *$30,000* per annum if the Government physician has served as a Government physician for more than twenty-four months.

For the purpose of determining length of service as a Government physician, service as a physician under section 4104 or 4114 of title 38 or active service as a medical officer in the commissioned corps of the Public Health Service under Title II of the Public Health Service Act (42 U.S.C. ch. 6A) shall be deemed service as a Government physician.

* * * * * * *

CHAPTER 89—HEALTH INSURANCE

Sec.
8901. Definitions.

* * * * * * *

8903b. Authority to readmit an employee organization plan.

* * * * * * *

§ 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) * * *

* * * * * * *

[*55]

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agree-

ments, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee [organization;] *organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;*

* * * * * * *

§ 8902. Contracting authority

(a) * * *

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other

than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

[(2)] *(3)* The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

* * * * * * *

[(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.]

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * *

[*56]

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term "provider of health care services or supplies" or "provider" means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term "individual covered under this chapter" or "covered individual" means an employee, annuitant, family member, or former

spouse covered by a health benefits plan described by section 8903 or 8903a; [and]

(C) an individual or entity shall be considered to have been "convicted" of a criminal offense if—

(i) * * *

* * * * * * *

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which a judgment of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity[.]; and

(D) the term "should know" means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under [subsection (b) or (c)] *subsection (b), (c), or (d)*, a provider is barred from participating in the program under this chapter, no payment may be made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

* * * * * * *

(b) [The Office of Personnel Management may bar] *The Office of Personnel Management shall* bar the following providers of health care services or supplies from participating in the program under this chapter:

(1) * * *

* * * * * * *

[(5) Any provider—

[(A)whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

[(B)that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.]

(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement [*57] *activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).*

(c) *The Office may bar the following providers of health care services from participating in the program under this chapter:*

(1) Any provider—

(A) *whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by*

a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially

in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.

[(c)] *(d)* Whenever the Office determines—

[(1) in connection with a claim presented under this chapter, that a provider of health care services or supplies—

[(A) has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

[(B) has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which [*58] are of a quality that fails to meet professionally recognized standards for such services or supplies;]

(1) in connection with claims presented under this chapter, that a provider has charged for a health

care service or supply which the provider knows or should have known involves—

(A) an item or service not provided as claimed,

(B) charges in violation of applicable charge limitations under section 8904(b), or

(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);

* * * * * * *

[(d)] *(e)* The Office—

(1) * * *

* * * * * * *

[(e)] *(f)* In making a determination relating to the appropriateness of imposing or the period of any debarment under this section (*where such debarment is not mandatory*), or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account—

(1) * * *

* * * * * * *

[(f)(1) The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.]

(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c)

shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).

* * * * * * *

(3) Any notice of debarment referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of time for which such debarment is to remain effective. *In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).*

(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such **[*59]** manner as the Office may by regulation prescribe, for termination of the debarment.

(B) The Office may—

(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period,

if the Office determines, based on the conduct of the applicant, that—

(I) there is no basis under [*subsection (b) or (c)*] *subsection (b), (c), or (d)* for continuing the debarment; and

* * * * * * *

[(6) The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.]

[(g)(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the provider in any such hearing.

[(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.]

(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided

in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court **[*60]** *shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the*

record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

[(h)] *(i)* A civil action to recover civil monetary penalties or assessments under subsection [(c)] (d) shall be brought by the Attorney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees Health Benefits Fund. *The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.*

[(i)] *(j)* The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the

individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, *which may be underwritten by participating affiliates licensed in any number of States*, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

* * * * * * *

[*61] § 8903b. Authority to readmit an employee organization plan

(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

(b) A contract for a plan approved under this section shall require the carrier—

(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.

§ 8909. Employees Health Benefits Fund

(a) * * *

* * * * * * *

(e)*(1)* Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

Conflicts Between State Health Insurance Requirements And Contracts Of The Federal Employees Health Benefits Carriers

U.S. Civil Service Commission

Many States have health insurance requirements that conflict with provisions of the contracts negotiated by the Civil Service Commission and the Federal Employees Health Benefits carriers. Some doubt and confusion exists on the part of the Federal health insurance carriers and the States regarding the applicability of State requirements to these contracts. GAO believes the Subcommittee on Retirement and Employee Benefits, Committee on Post Office and Civil Service, should consider legislation to clarify whether State requirements can alter the terms of contracts negotiated under the Federal Employees Health Benefits Act.

MWD-76-49 *Oct. 17, 1975*

B-164562

The Honorable Richard C. White
Chairman, Subcommittee on Retirement
and Employee Benefits
Committee on Post Office and Civil Service
House of Representatives

Dear Mr. Chairman:

Your February 20, 1975, letter asked for information on State health insurance requirements which conflict with contracts negotiated between the Federal Employees Health Benefits carriers and the Civil Service Commission. You asked that we identify those State health insurance requirements which conflict with contracts of these carriers, and if feasible, determine (1) what the increase in costs would be to the Federal Employees Health Benefits program if the contracts were changed to include all benefits required by the States and (2) what the savings would be if these State requirements were preempted by Federal statute.

The report discusses various State conflicts, the carriers' methods of dealing with these conflicts, and the position of the Civil Service Commission and certain carriers regarding the applicability of State requirements to the Commission's health insurance contracts. Because of an absence of cost data, we could not determine what the increased cost to the Federal Employees Health Benefits program would be if the contracts were changed to include all benefits required by the States, nor could we determine what the savings would be if the State requirements were preempted by Federal statute.

We found that (1) some doubt and confusion exists among the carriers and the States regarding the

applicability of State requirements to these contracts and (2) the States are becoming increasingly active in establishing and enforcing health insurance requirements. Accordingly, we believe that the Subcommittee should consider legislation to clarify whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

As your office requested, we did not obtain the Commission's or the carriers' formal comments on this report, but the contents of the report were discussed with Commission officials.

Sincerely yours,

s/

Comptroller General
of the United States

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ABBREVIATIONS

CSC Civil Service Commission

FEHB Federal Employees Health Benefits
GAO General Accounting Office
NALC National Association of Letter Carriers
GEHA Government Employees Hospital Association

[*i]

COMPTROLLER GENERAL'S REPORT

CONFLICTS BETWEEN STATE HEALTH INSURANCE REQUIREMENTS AND CONTRACTS OF THE FEDERAL EMPLOYEES HEALTH BENEFITS CARRIERS

U.S. Civil Service Commission

DIGEST

The Federal Employees Health Benefits program provides health insurance coverage to program participants through contracts negotiated between the Civil Service Commission and health plan carriers. These contracts specify the benefits to be provided by the plans and the premium cost which is shared by the Government and enrollees. (See p. 1.)

Some States have established health insurance requirements that conflict with the provisions of these contracts, such as requiring recognition of certain practitioners not covered by Federal Employees Health Benefit plans. These conflicting requirements have not, to date, greatly increased the costs of the Federal Employees Health Benefits program. (See p. 5.)

Many States have not attempted to enforce their requirements that conflict with these health

plans. In other States, the carriers have been successful in convincing the States that the Federal employees' plans are exempt from State requirements. Other States have enforced their requirements but have not done so uniformly for all carriers in the Federal program. (See p. 5.)

[*ii] For example, the Indemnity Benefit Plan pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State. Six employee organization plans pay for chiropractic services only in New York and Montana where State laws require coverage for such services. The Service Benefit Plan has been required to pay for these services only in Maryland and Oklahoma. Even in the States that have enforced conflicting requirements, few Federal enrollees are aware of the States' requirements, and, as a result, most enrollees do not attempt to obtain reimbursement for chiropractic services. (See p. 9.)

The cost of revising the carriers' contracts with the Civil Service Commission to include all benefits required by States is difficult to estimate because of such unknown factors as the potential utilization of these benefits. However, the Indemnity Benefit Plan believes they would have to increase their premiums by as much as five percent. (See p. 13.)

Some plans have requested the assistance of the Commission in obtaining exemptions from the State requirements, but the Commission has consistently taken the position that the States have the authority to regulate the plans. (See p. 16.)

Because of the large number of State requirements that conflict with the plans, and indications that States are becoming more active in enforcing them, it appears that such requirements could increasingly affect the benefits and costs of the program. (See p. 16.)

[*iii] CONCLUSIONS

There is some doubt and confusion on the part of the carriers and the States regarding the applicability of various State health insurance requirements to the Federal Employees Health Benefits program contracts.

As a result, decisions regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with the carriers' contracts with the Commission, these conflicting requirements can be expected to result in:

-- increased premium costs to both the Government and the program enrollees and

-- a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States. (See p. 16.)

RECOMMENDATION TO THE SUBCOMMITTEE

In view of (1) the doubt and confusion that exists among the health benefit carriers and some States and (2) the increased activity of the States in estab-

lishing and enforcing health insurance requirements, GAO recommends that the Subcommittee consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act. (See p. 17.)

[*1] CHAPTER 1

INTRODUCTION

We reviewed the problems resulting from conflicts between the benefits and services provided under the Federal Employees Health Benefits (FEHB) program and various State requirements in response to a February 20, 1975, request from the Chairman, Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service. (See app. I .)

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The Federal Employees Health Benefits program, established by the FEHB Act of 1959, provides health insurance coverage for about 3 million Government employees and annuitants and 6 million dependents. The cost of the program, which is shared by participating employees and the Government, was about $1.6 billion for fiscal year 1974, of which the Government's share was estimated at $960 million. The total cost of the program for fiscal year 1976 will be about $2 billion.

The program is administered by the Civil Service Commission (CSC) which contracts for coverage through the following four types of health plans:

-- Service Benefit Plan: A Government-wide plan under which the carrier, Blue

Cross/Blue Shield, generally provides benefits through direct payments to physicians and hospitals. About 5.6 million of the 9 million program participants are covered by this plan.

[*2] -- Indemnity Benefit Plan: A Government-wide plan under which the carrier, Aetna Life Insurance Company, provides benefits by either reimbursements to the employees or, at their request, direct payments to physicians and hospitals. About 1.3 million program participants are covered by this plan.

-- Employee Organization Plans: These plans, available only to individuals and members of their families who are members of the sponsoring organizations, provide benefits either by reimbursing employees or, at their request, by paying physicians and hospitals. Twelve such plans provide coverage to about 1.5 million program participants.

-- Comprehensive Medical Plans: These plans, available only in certain localities, provide (1) comprehensive medical services by teams of physicians and technicians practicing in common medical centers or (2) benefits in the form of direct payments to physicians with whom the plans have agreements. Thirty-two such plans provide benefits to about 600,000 program participants.

The premium costs to the Government and enrollees and the benefits provided by each of the FEHB

plans are specified in contracts negotiated each year by CSC and the carriers. Although the benefits and premium costs may differ among the various plans--and between various options available under the same plan--all those enrolled under a particular plan and option are entitled to receive the same benefits and pay the same premiums.

[*3] Even though the contracts between CSC and the various FEHB carriers require uniform coverage for all enrollees in each option of each plan, a few States have required certain FEHB carriers to provide benefits or services not covered in the contracts with CSC.

In addition, some FEHB carriers are being taxed by States while others are not, which affects the premium rates. For example, some States require certain FEHB carriers to pay premium taxes while other FEHB carriers are exempt and some States require reserves for contingencies and epidemics, in addition to the reserves required by CSC. We have previously reported on the tax and reserve issues (B-164562, Oct. 20, 1970, May 22, 1972, and Nov. 7, 1974). The premium taxes paid by the various FEHB carriers in calendar year 1974 are shown in appendix II.

SCOPE OF REVIEW

The objective of our review was to obtain information on the conflicts between State health insurance requirements and the FEHB program and the effect such conflicts have on the cost of the program.

The review included an examination of records and discussions with officials at CSC headquarters, Washington, D.C., and at the offices of the carriers for the Service Benefit Plan, the Indemnity Benefit

Plan, and several of the employee organization plans. We did not visit all of the States or review all State laws and regulations; rather, we obtained most of our information on actual and potential conflicts in [*4] benefits and services from the FEHB carriers. Also, because of the absence of cost data pertaining to benefits or services required by States but not included in FEHB carriers' contracts with CSC, we could not determine (1) the cost to the program if all such benefits were included in the FEHB plans' contracts or (2) the savings if such State insurance requirements were preempted by Federal law.

[*5] CHAPTER 2

CONFLICTS BETWEEN STATE HEALTH INSURANCE REQUIREMENTS AND FEHB CONTRACT PROVISIONS

A number of State health insurance laws, regulations, and Attorney Generals' opinions are beginning to have an impact on the coverage provided under the FEHB plans. It can reasonably be expected that if these State requirements were publicized and strictly enforced by the States, the costs of the FEHB program could be increased substantially.

The existing conflicts between the FEHB carriers' contracts with CSC and the State requirements have, to date, not had a great impact on the FEHB program costs, primarily because

- even when the States have ruled that conflicting State health benefit requirements are applicable (even if not provided in the FEHB contract), the FEHB enrollees do not usually know about the State laws and regulations and therefore do not pursue their claims with the carriers and

-- both the States and the carriers are unsure of the States' rights to impose State requirements on Federal contracts.

In connection with the latter point, many States that have insurance requirements that apparently conflict with benefits and services provided by FEHB plans have not attempted to enforce their requirements. In other States, the FEHB carriers have been successful in convincing the States that they are exempt from State requirements. [*6] Some States that have enforced their requirements, have not done so uniformly to all FEHB plans in those States. This could be, however, because enrollees in some plans are not aware of State requirements.

CSC's position on this matter has been that (1) the States have the authority to regulate and tax FEHB carriers, (2) it neither interprets nor enforces State laws, and (3) the FEHB carriers are free to take whatever steps are available to test the applicability of State laws.

There is some doubt and considerable confusion among the carriers and the States regarding the applicability of various State health insurance laws to the FEHB contracts.

As a result, decisions regarding the health benefits or services allowed under the FEHB program are, to a large extent, made on a State-by-State and a claim-by-claim basis. Descriptions of conflicts that the individual carriers have experienced with various State requirements follow.

INDEMNITY BENEFIT PLAN

Although Aetna has usually been successful in convincing State insurance commissions that the In-

demnity Benefit Plan is exempt from State laws and regulations, there have been exceptions.

Aetna has established standard responses to satisfy various States on the applicability of State insurance laws and regulations to the Indemnity Benefit Plan contracts. If a State asks why Aetna has denied [*7] a claim for a certain expense not covered by the plan, but required by the State, Aetna's first response has been that the plan is a group policy issued in the District of Columbia and is, therefore, not subject to the laws of that State. Until recent years, the States generally accepted this response.

According to Aetna officials, however, a few States have recently passed laws applicable to all group contracts regardless of where the policy was issued. In addition, Aetna stated that a few States have taken the position that, regardless of the wording of the State law, it applies to all contracts regardless of where they were issued. In these instances, Aetna tells the State that its plan is written pursuant to a special act of the Federal government and is not subject to State law or regulation. According to Aetna, this reply was accepted by all States until 1973.

In 1973, however, Nevada refused to recognize this argument and directed Aetna to pay for chiropractic services which were not included in its FEHB contract.

In June 1973, Nevada officials informed Aetna that in 1970 the State Legislature amended Nevada statutes to require coverage of chiropractic services and that Nevada's Attorney General had rendered an opinion in February 1973 which stated, in part, that:

"Nevada law currently requires coverage for chiropractic services in all individual, group or blanket health policies used in this State, regardless of the effective date or date of issuance to any such policy."

[*8] In September 1973, Nevada told Aetna that whenever the Indemnity Benefit Plan covers Nevada residents it is subject to State law. Nevada further stated that unless Federal legislation expressly preempted the Indemnity Benefit Plan from State law, Aetna's contention of Federal preemption would not be considered valid.

As a result, Aetna proposed to CSC that it either (1) join Aetna in court action to contest Nevada's requirements or (2) allow Aetna to include chiropractors in the plan's definition of doctors. Aetna estimated the additional premium necessary to cover this inclusion would range from 1 to 2 percent (about $2-4 million).

CSC declined to participate in a suit over this matter, but authorized Aetna to pay claims for services provided by chiropractors in Nevada. Aetna accepted CSC's decision, with the understanding that the cost of such claims be paid by CSC from its contingency reserve. This understanding was subsequently incorporated into the Indemnity Benefit Plan contract.

Aetna has successfully contested claims for chiropractic services in Missouri, Ohio, South Dakota, and Washington. In all cases, Aetna convinced the States that since the Indemnity Benefit Plan was under the FEHB program, it is exempt from State requirements. Beneficiaries in California and Florida have also had disputes with Aetna over claims for

chiropractic services. The insurance commissioners in these States, however, ruled that they lacked jurisdiction over FEHB plans.

[*9] In addition, Aetna has been involved in a dispute with Maryland concerning services provided by certain psychologists. Maryland law requires payment for services provided by licensed or certified psychologists, regardless of whether they are clinical psychologists. Aetna denied a claim in Maryland on the grounds that a licensed psychologist was not a clinical psychologist as defined in its contract. However, Aetna subsequently paid this claim as directed by the State.

According to Aetna officials, they have also disputed claims involving various State requirements in Montana, North Dakota, and Texas. Aetna did not give us details on these disputes but said no payments have been made for the disputed claims.

Aetna provided us examples of recent actions by States that may increasingly affect the FEHB plans (see app. III). In one example, the Nevada legislature enacted a law, effective July 1, 1975, requiring health insurance policies to include coverage for services by persons licensed in Nevada to practice traditional oriental medicine, including acupuncture. According to Aetna officials, payment may have to be made for these services, which are not included in its FEHB contract.

Aetna officials told us that annual premium fees for the Indemnity Benefit Plan would have to be increased by 5 percent or about $11 million, to cover all benefits required by States but not included in the FEHB contract. Aetna believes that FEHB plan carriers should be exempt from State requirements on

the grounds that the FEHB Act preempts State regulations.

[*10] SERVICE BENEFIT PLAN

The Service Benefit Plan, provided by the National Associations of Blue Cross and Blue Shield plans, has also experienced conflicts with States involving practitioners and benefits. We were told by an association official that State conflicts have been discussed with CSC, but the associations have not formally requested CSC to help them contest the right of States to enforce their requirements.

Although freestanding surgical facilities are not covered under the Service Benefit Plan, because these facilities do not meet the plan's criteria for hospitals, information provided by CSC indicates that the plan makes payments for services of such facilities in 21 States. An association representative said recognizing these facilities was a management decision, since recognition is required by law in some States. CSC has not objected to the plan's coverage of treatment in these facilities, because it is less expensive than providing similar services in regular hospitals and, therefore, does not adversely affect the cost to the FEHB program.

Chiropractic services are not a covered benefit under the Service Benefit Plan. However, according to the carrier for the plan, payment is made for these services in Maryland and Oklahoma at the insistence of these States. The Service Benefit Plan has not been required to make payment for chiropractic services by any other State, including Nevada, which has required payment for these services by Aetna's Indemnity Benefit Plan. This could be because en-

rollees of the Service Benefit Plan are unaware of the State's requirements.

[*11] Other State regulations which conflict with the Service Benefit Plan, but have not been contested as yet, involve treatment for nervous and mental conditions, alcoholism, and drug addiction. For example, North Dakota recently passed a law requiring health insurance coverage for persons suffering from mental illness, alcoholism, and drug addiction. This law requires that benefits be provided for treatment by partial hospitalization which is defined as "that level and intensity of treatment that is greater than outpatient treatment, but less than inpatient treatment." However, the Service Benefit Plan does not cover such partial hospitalization.

Similarly, the Massachusetts legislature has passed a law--to become effective on January 1, 1976--which provides guidelines on benefits for nervous and mental conditions and alcoholism. The law requires that a group medical service agreement in that State include provisions for payment of benefits for inpatient confinement in a mental hospital for at least 60 days of any calendar year. The Service Benefit Plan, however, has a lifetime maximum of $50,000 for benefits provided for nervous conditions and mental illness.

Also under Massachusetts law, coverage of at least $500 will be required for outpatient services at any licensed alcoholism treatment facility. The Service Benefit Plan recognizes only a facility meeting its definition of hospital.

[*12] EMPLOYEE ORGANIZATION PLANS

A National Association of Letter Carriers (NALC) official stated their plan is not paying for

any benefits or services not covered in their FEHB contract. Accordingly, NALC has refused to pay claims for chiropractic services in Oklahoma; the State has not contested NALC's action.

NALC was the only employee organization plan that provided us estimates of the cost to cover those benefits required by States but not covered in its FEHB contract. NALC estimated that its annual premium fees would have to be increased by $4 million to cover the services of chiropractors and by $3 million to cover the services of general psychologists.

This position contrasts to that of the Mutual of Omaha Insurance Company, which underwrites six FEHB employee organization plans. A Company official said New York and Montana require coverage of chiropractic services and the six FEHB plans which it underwrites are complying with these requirements.

The Government Employees Hospital Association (GEHA) cited several instances where it believed conflicts existed between State requirements and its FEHB contract. One of these involved the recognition of psychologists, which, at one time, were not covered under GEHA's FEHB contract.

A conflict occurred in Missouri where GEHA was directed to--and did--pay for psychiatric services rendered by an osteopath. GEHA denied the claim because osteopaths were not licensed to provide psychiatric services. [*13] The State's basis for directing payment was that GEHA's contract provided for services rendered by doctors of medicine and licensed doctors of osteopathy.

GEHA officials also stated that in some cases they were required by Illinois and Nevada to pay for

certain chiropractic services which were not provided for in their FEHB contract; however, in other similar cases in the same States, GEHA was not required to recognize or pay for these services.

GEHA currently has a lawsuit pending in California concerning the payment of chiropractic services. The suit was filed by a chiropractor who was refused payment for services required by State health insurance laws, but not covered under GEHA's FEHB contract.

CARRIERS' CONTACTS WITH CSC REGARDING CONFLICTS

Several of the FEHB carriers--principally Aetna and NALC--have sought CSC assistance in attempting to resolve the conflicts between State health insurance requirements and FEHB contract requirements.

As previously mentioned (see p. 6), Aetna's position is that FEHB carriers should be exempt from State requirements because the FEHB Act preempts State regulations. Aetna bases its position on the McCarran-Ferguson Act (15 U.S.C. 1012(b)), which states, in part, that:

> "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance * * *." (Emphasis added)

[*14] Aetna points out that the FEHB Act states that "each contract shall contain a detailed statement of benefits offered and shall include such maximum, limitations, exclusions, and other definitions of bene-

fits as the Commission considers necessary or desirable." Therefore, according to Aetna, the FEHB Act specifically relates to the "business of insurance" and clearly comes within the exception section of the McCarran-Ferguson Act and should not be subject to State regulations.

Aetna informed CSC of its opinion that the terms of the FEHB contract must take precedence over State regulations, to protect the FEHB program from conflicting regulations and to permit uniform coverage for all Federal employees enrolled in the Indemnity Benefit Plan.

NALC has attempted to obtain exemption from State insurance regulations since Wisconsin, in December 1968 (1) required NALC to pay approximately $207,000 in premium taxes, penalty assessments, and penalty interest because NALC had not obtained a State license and (2) had, according to Wisconsin, engaged in unauthorized transaction of insurance business.

In August 1970, NALC requested CSC to support NALC's position that the FEHB Act supersedes State licensing of health benefits plans such as NALC's, and that the taxes, penalties, and interest payments imposed by Wisconsin conflict with the FEHB Act.

NALC's legal opinion submitted to CSC stated that Wisconsin's application of State insurance licensing requirements to an employee organization plan established under the FEHB Act violates the Supremacy Clause (Clause 2 of Article VI) of the United States Constitution, since "it intrudes upon an area preempted by federal law, obstructs and [*15] impairs the operation of an Act of Congress and frustrates effectuation of its policy."

In December 1970 and January 1971, two other employee organization plans--the United Federation of Postal Clerks and Rural Carrier Benefit Plan--joined NALC in seeking an amendment to the FEHB Act so that FEHB contracts would supersede, or take precedence over, State laws which conflict with FEHB contracts.

CSC's POSITION

CSC's position has been that "the States have the authority to both regulate and tax health insurance carriers operating under the Federal Employees Health Benefits Program of chapter 89 of title 5 of the United States Code." In response to the FEHB carriers' requests, CSC told the carriers that

- the FEHB Act was not designed to regulate the insurance business or to override any State regulatory scheme,
- no legal basis exists for CSC to issue a regulation restricting the applicability of State laws to FEHB contracts,
- CSC neither interprets nor enforces State laws, and
- the carriers are free to pursue whatever steps are available to them to test the applicability of a State law in a given situation.

In this regard, CSC's General Counsel has not agreed with the carriers' contention that the FEHB Act is exempt from State regulation because of the McCarran-Ferguson Act. Moreover, he does not believe the "supremacy clause," also known as the preemption doctrine, could be used [*16] as a legal

basis for issuing a regulation restricting the applicability of State laws with regard to FEHB contracts.

In a June 1975 letter to Aetna, CSC's Deputy General Counsel said the legislative history of the FEHB Act is nearly devoid of references to the relationship between the FEHB Act and State laws regulating the business of insurance. He pointed out that the House Committee on Post Office and Civil Service stated in a 1970 report that:

> "it is recommended that the Civil Service Commission take appropriate action to inform carriers that the fact they are administering a Federal contract is no reason for circumventing compliance with applicable State laws."

The Deputy General Counsel concluded that this remark, along with others, indicates that State law should be controlling. Furthermore, he said there is no mention of the McCarran-Ferguson Act in the legislative history of the original FEHB laws or subsequent amendments to it. Therefore, he does not view the history of the FEHB Act as supporting Aetna's position that the act was intended to constitute a specific and explicit congressional enactment regulating the business of insurance.

On June 26, 1975, Aetna requested CSC's official position of the applicability of State requirements to FEHB carriers. As of October 9, 1975, CSC had not responded.

CONCLUSIONS

There is some doubt and confusion on the part of the FEHB carriers and the States regarding the applicability of various State health insurance requirements to the FEHB contracts. As a result, deci-

sions [*17] regarding health benefits or services required by States, but not covered under the Federal Employees Health Benefits program, are made, to a large extent, on a State-by-State and a claim-by-claim basis.

Because the States are becoming more active in establishing and enforcing health insurance requirements which conflict with the carriers' contracts with CSC, these conflicting requirements can be expected to result in

- increased premium costs to both the Government and FEHB plan enrollees and
- a lack of uniformity of benefits for all enrollees in the same plan, which results in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

RECOMMENDATION TO THE SUBCOMMITTEE

In view of (1) the doubt and confusion that exists among the health benefit carriers and some States and (2) the increased activity of the States in establishing and enforcing health insurance requirements, we recommend that the Subcommittee consider legislation to clarify its intent as to whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the Federal Employees Health Benefits Act.

APPENDIX I

APPENDIX I

Ninety-Fourth Congress

U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS
OF THE
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
B-345-B RAYBURN HOUSE OFFICE BUILDING
Washington, D.C. 20515

February 20,1975

B-164562

The Honorable Elmar B. Staats
Comptroller General of the United States
U.S. General Accounting Office
441 G Street, NW.
Washington, D.C. 20548

Dear Mr. Staats:

It has recently come to our attention that certain inequities exist in the Federal Employees Health Benefits (FEHB) program due to conflicts between the FEHB contracts and various State statutes. For instance, in Arizona, benefits for chiropractic services are paid under the service benefit plan because such benefits are required by State statute even though they are not paid for Federal employees in all States. In addition, certain States have statutes which require health benefit plans to maintain special contingency reserves in addition to the reserves held under the FEHB program.

I would like the General Accounting Office to identify those State health insurance requirements which are in conflict with contracts of the FEHB carriers. If feasible, I would also like to know (1) [*19] what the increase in costs would be to the FEHB program if the contracts with the FEHB carriers were changed to include all benefits required by such State statutes and (2) what the savings would be if such State statutes were preempted by Federal statute. I would also be interested in any legislative changes that you believe might improve this situation.

Sincerely yours,

s/

Richard C. White
Chairman

[*20]

APPENDIX II APPENDIX II

PREMIUM TAX EXPENSES
FOR CALENDAR YEAR 1974
BY FEHB CARRIER

Plan	Premium tax expense in 1974	Number of enrollees	Per enrollee (annual)
Service Benefit Plan	$1,063,982	1,844,309	$ 0.58
Indemnity Benefit Plan	5,367,212	475,118	11.30

American Federation of Government Employees	149,914	15,317	9.79
Government Employees Hospital Association	-0-	23,067	-0-
National Association of Letter Carriers	-0-	147,964	-0-
Postmasters Benefit Plan	118,561	8,574	13.83
Rural Letter Carriers	337,501	28,836	11.70
American Foreign Service	96,837	10,031	8.66
Government Employees Benefit Association	99,184	8,486	11.69
Canal Zone	200,151	17,865	11.20
Special Agents Mutual Benefit Association	173,135	17,842	9.70
Mail Handlers	256,062	23,596	10.85
National Alliance	40,209	3,866	10.40
American Postal Workers	-0-	158,194	-0-

APPENDIX III APPENDIX III



151 Farmington Avenue
Hartford, Connecticut 06115

Malcolm McIntyre
Manager
Government Relations Group
Division

September 23, 1975

Mr. Gerald Miller
Supervisory Auditor
Government Accounting Office
Audit Site, Room 2456
U.S. Civil Service Commission
1900 E Street, N.W.
Washington, D.C. 20415

Dear Mr. Miller:

In accordance with your most recent request, I have reviewed some state laws enacted recently and inasmuch as these new statutes could impact on the payment of benefits and the implementation of the Federal Personnel Manual 890.1 regulations, as they relate to health benefits, I will give you a short resume of each law and regulation.

Arkansas has a law which became effective June, 1975, which requires recognition of chiropractors' charges if such services would have been payable if rendered by a physician.

In Colorado, a law will become effective on January 1, 1976 which will require basic coverages to include benefits for at least 45 days of in-patient care

or 90 days partial hospitalization (3-12 hours in hospital or licensed psychiatric hospital) for mental illness treatment. Comprehensive medical policies must include out-patient services for treatment of mental and nervous conditions which may be limited to $1,000 in a 12-month period. Also, coinsurance may not exceed 50%.

Another law in Colorado which will also be effective January 1, 1976 requires insurers to offer for inclusion in group health policies coverage for treatment of alcoholism. Minimum benefits required to be offered include 45 days in-patient care in a licensed hospital or a facility licensed by the Department of Health, and out-patient benefits to the extent of $500 in a 12-month period.

Effective October 1, 1975, a law in Connecticut will require that an employee or dependent, if the employee becomes ineligible for continued participation in a plan for any reason including death, be allowed to continue insurance for up to 39 weeks or until covered by another group plan after insurance would otherwise cease, upon payment of premiums to the policyholder.

Another law, which became effective on May 28, 1975, in Connecticut, amends the Mental Illness Law to make it applicable to renewed [*22] contracts to increase the covered period of confinement for mental and nervous conditions from 30 to 60 days, and to increase the level of coverage for out-patient treatment from $500 to $1,000.

Effective October 1, 1975, another law will become applicable in Connecticut which mandates home health care benefits. The maximum offered cannot be less than 80 visits in a calendar year or in any

continuous period of 12 months. Of concern to us is the fact that such care could be rendered by a person who does not meet the requirements for coverage under the provisions of the Indemnity Benefit Plan or the Uniform Plan.

In Idaho, a new law became effective on July 1, 1975. One of the provisions of this law is that any medical policy which includes maternity benefits must, upon discontinuance, provide the maternity benefits that would have been payable to persons pregnant at the time of discontinuance had the policy remained in force for a period of 12 months following discontinuance.

Effective October 1, 1975, a law will go into effect in Illinois which will require group coverage to continue for a period not to exceed six months from an employee's "termination date" (date employee fired, laid off, etc.), provided the employee agrees to pay the premium at the previous rate. The employer must meet special notice requirements to permit the terminated employee the option to elect the continued coverage. This law will only be effective until July 1, 1977.

In Louisiana, effective November 1, 1975; a new law will require recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

The Maryland Insurance Department has a proposed regulation which would prohibit coordination of benefits between "no-fault" automobile insurance and medical insurance policies. This proposed regulation would also be extraterritorial in nature. Of course, this would impact directly on the "double coverage" provision contained in the Indemnity Benefit Plan.

A law becomes effective in Massachusetts on January 1, 1976 requiring that all group hospital and surgical expense policies covering Massachusetts residents, and to individual policies issued in Massachusetts, offer benefits for expenses arising for treatment of mental illness at least equal to requirements that in-patient benefits for treatment in a mental hospital will be provided for at least 60 days in a calendar year if the hospital is under the supervision of the Department of Mental Health, or licensed by that Department, and for confinement in a licensed general hospital, benefits are to be provided on the same basis as for any other illness. For out-patient benefits for treatment of mental and nervous disorders, they are to be covered to the extent of $500 over a 12-month period if services are provided by a comprehensive health service organization, by a licensed or accredited hospital, by a community mental health clinic or day-care center providing mental [*23] health services as approved by the Department of Mental Health, or by consultations, diagnostic or treatment sessions when administered by a licensed psychotherapist or psychologist.

In Minnesota, a law was effective July 1, 1975 which requires coverage for in-patient hospital and medical expenses on the same basis as other benefits for the treatment of emotionally handicapped children in a residential treatment facility licensed by the Commissioner of Public Welfare.

Also in Minnesota, a law became effective on August 1, 1975 which requires coverage of at least 90% of the first $600 in any 12-month period for consultation, diagnosis and treatment for mental and nervous disorders while the insured is not a bed patient in a hospital.

Another Minnesota law, which was effective May 15, 1975, requires that coverage under a group health insurance policy, upon termination of employment, must be continued until either the employee is reemployed and eligible for another group health care coverage or for six months.

In Nevada, a law became effective July 1, 1975 which requires benefits for home health care or health-supportive services. On this same date, another law became applicable in Nevada which requires recognition of the charges made by a licensed doctor of traditional Chinese Medicine (acupuncture).

Effective January 1, 1976, New Hampshire will have a new law which requires benefits for losses arising from mental or nervous conditions to be at least equivalent to 45 days of in-patient confinement, and 100% of the first five visits (80% thereafter) for out-patient coverage limited to $500 in a calendar year.

On June 5, 1975, a law became effective in New Jersey which requires recognition of a chiropractor's charges if such services would have been payable if rendered by a physician.

In Oklahoma, there is a new law requiring that group health policies issued or delivered on or after January 1, 1976 provide for continuation of coverage for 30 days after termination of such policy, and requires specified extended benefits to employees who have been covered under the policy for at least six months, for a continuous loss which commenced while the insurance was in force.

On July 31, 1975, a law became effective in Wisconsin which requires coverage for out-patient services at a hospital or out-patient treatment facility, including services of a physician in connection with alcohol-

ism or drug abuse to the extent of the first $500 in any calendar year. The law, however, makes a distinction in mandating the level of coverage for mental illness. Out-patient treatment for mental illness which is rendered at any place other than under a community mental health program established by Section 51.42 of the Wisconsin Statutes, need only be covered to the extent of $500 in a [*24] calendar year. However, out-patient mental illness treatment rendered under a community mental health program must be paid for the first $500 in any calendar year. The effect of this is that no deductible or coinsurance is permitted until the $500 limit is reached in connection with out-patient alcoholic treatment of mental illness, no matter where the treatment is rendered, and in connection with the treatment of mental illness, no deductible or coinsurance is permitted until the $500 limit is reached if the out-patient care is rendered under a community mental health program. However, if the out-patient mental health care is rendered somewhere other than under the community mental health program, a deductible and coinsurance is permitted.

Of course, I am sure you realize that there are many other statutes effective in various states which would impact on the benefit provisions of both the Indemnity Benefit Plan and the Uniform Plan, as well as the Federal Employees Health Benefits regulations. I have pointed out the foregoing laws and regulations just to give an indication of how the additional benefits, for which premiums have not been considered under these plans, would increase the claim benefits payable. One must also consider the implications on the increased administrative costs inherent to us in tracking and providing coverage under all of the various state laws under these plans, and the implied

necessity of having to, in the future, print brochures for each state showing the various coverages which would be in effect and the benefits which would be payable in each state.

As relates to the regulations and laws of the states concerning continuation of coverage, etc., it would be necessary for the Civil Service Commission to make a determination as to whether or not the states' laws or regulations would apply, or whether the Federal Employees Health Benefits regulations would apply under these circumstances.

All in all, I am sure that you realize our assumption that a 5% premium increase would be necessary for the Indemnity Benefit Plan for 1976 in order to pay benefits for services required by the various states is only for a one-year period, and that the cost would escalate in the future as more and more of the states' laws became applicable to these plans, or the states passed laws which would impact on the benefit structures of these plans.

I very much appreciate your request for this additional information, and please be assured that if I may be of further assistance to you, you need only call upon me.

Sincerely,

s/

Malcolm McIntyre, Manager
Group Government Relations

MM/cb